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Institute of Public Health

Three Objectives

Said an astute Canadian financier, "The only advantage of an objective is to go so far beyond it that it cannot be seen." Imbued with that spirit and aware that the future growth of the National Association is conditioned entirely by that of its constituent parts —the nine Provincial Associations (for it is a federation of those) —the Executive Committee of the Canadian Nurses Association has outlined three objectives to ensure purposive and effective effort throughout the new year.

An Increased Membership:

It is computed that in Canada there are approximately 18,058 registered nurses and that the membership of the nine Provincial Associations is 7,736. The majority of the provinces require that every registered nurse be a member of a Provincial Association. A minority do not. The difference between the two figures constitutes the potential increase in provincial membership and consequently of the Canadian Nurses Association. Such is the challenge!

A Successful Termination of the Survey of Nursing Education in Canada:

Manifest are the indications that Canadian nurses are giving unstinted support to this meritorious project. Fortunately, funds for its completion are already available. The sustained interest of every nurse is enlisted in helping to make effective its conclusions when published. Difficult as are the detailed mechanics of such a study, added patience and ingenuity will be needed in the cultivation of a body of opinion sufficient to bring to fruition its deductions and recommendations.

A Full-Time Editor for The Canadian Nurse:

Not less worthy is the third objective. Many Canadian nurses are supporting loyally and consistently the official organ of the Association. Compared with the total number of registered nurses in Canada the subscription list reflects an unwarranted discrepancy. The surest way to make possible the appointment of a full-time Editor is through increased support of the present magazine: more subscriptions: more assistance in securing worthy content.

The Executive Committee of the Canadian Nurses Association presses the contention that in a multitude of New Year's resolutions should be included those which will lead to the general and active support of professional interests to the end that such objectives may be reached and mayhap exceeded.

—*Florence H. M. Emory.*

The Graduate Nurses' Need for Life Insurance

By **ELIZABETH F. ROBB**, St. Catharines, Ontario

Of all the professions in which present-day women are engaged, there is none more noble, requiring more unselfish and untiring effort than the nursing profession. For this reason, the years of active service in this calling are fewer in number than in any other. It is, therefore, not only wise, but extremely necessary for all nurses to begin early in their careers to make some provision for their years of decreasing energy so that when they reach the sunset of life they may not find themselves dependent on friends, or what is worse—on charity.

With few exceptions, the working woman of today finds it impossible to save anything like a sum sufficient to provide for her declining years, and this is particularly true of the graduate nurse because of her precarious and ever-varying income. Quite often the most careful savings from a period of plentiful cases are eaten up when work is more scarce, but what is more frequently the case with the majority of nurses, very little provision is made in the former period to cover the urgent needs of the latter.

Many women, nurses and others, devote the best years of their lives to the education of younger brothers and sisters, or possibly to the support of invalid parents, only to find that an old age is upon them for which they are totally unprepared. Of course those for whom they have sacrificed themselves are usually grateful, but since the younger children seldom have anything to spare and the parents have no means of their own, they can do little towards repaying the debt. All the benefactor receives is sincere sympathy and helpful suggestions, but these don't go very far towards providing a warm shelter, good food, and the leisure to which a woman is entitled at the end of her working days.

Various types of investments appeal to the woman who has been unable to provide for her future needs. The recent stock crash and the ensuing poverty and distress have proved that this method of augmenting one's income is extremely unreliable, to say the least. Many of our leading financiers, men with long years of experience in this line have suffered loss along with the small investor. How then can a woman in a profession which spares so little time as nursing expect to gain the experience to invest her income wisely and safely?

When you consider, as we have, that professional women are unable to save sufficient for a comfortable retirement, that investments are liable to dissipate whatever little may have been saved, is it any wonder that 95% of this class are dependent on friends and relatives and even on charity at the age of 60? All women, whatever their profession, are alike in one respect—they look forward to a time when they will be able to take life easier, to read the books and see the plays for which they have had no time, perhaps to travel, and in general to stop worrying over others and be free to spend a little time on themselves. Members of the nursing profession can appreciate these little comforts and indulgences, for they, of all women, have had to deny themselves the most.

You ask, "How can a woman realize her ambition? It appears that unless she has an independent income she is doomed to an old age of poverty and dependency." The answer is this: "By securing a Life Insurance policy a woman can assure herself of a certain definite income, starting at the age 50 or 55, and continuing for the rest of her life. There is no other means to that end." Ask your friends how much they are able to save in a year. They will tell you, "Sometimes

$300, sometimes $200, some years less than that. The thing you can't help noticing is that the amount is usually varying and uncertain from year to year. Unless one has a definite goal, small sums are usually wasted, and taken over a period of time, these small sums grow to very large sums. A Life Insurance policy provides the necessary goal, and utilizes these small amounts along with other savings to attain it. People who find it almost impossible to save anything unassisted have comparatively little difficulty in meeting their Life Insurance payments, and at the maturity of their policies have amounts of money which they would never have had otherwise.

A few weeks ago I was attending a meeting of one of our local women's clubs. The chairman introduced the speaker, a prominent welfare worker from a large city in the United States. She told us of her work among her city's poor and needy, and near the end of her talk she said, "Now I have given you an idea of what might be called the more difficult and unpleasant side of my work I should like to tell you of a little incident which gave me a great deal of pleasure. Visits to the blind are part of our work. I was assigned to call on an old lady in a fairly good section of the city. I found her in a cozy, well-furnished little three-roomed apartment, reading, as the blind do, with her hands. She was a fragile, delicate type of woman with a sweet face which reflected her very joy in living. She told me of her life, how she had been a school teacher with a fair sized income; while still very young she had been induced to buy an Endowment policy, which matured when she was forty. She had invested the proceeds in an Annuity which became payable in monthly installments at the age of 50, the payments guaranteed to last her for life. Her sight commenced to fail her when she was about 49, and by the time she began to receive her Annuity payments she was totally blind. I asked her if the loss of her sight was not a terrible shock to her. 'If it had not been that I had my little income to keep a roof over my head and coal in my grate I think I should have gone mad when I lost my eyesight', she said, 'but how can I be unhappy in this pleasant little home, knowing as I do, that I shall never want. I can find no words in which to express my gratitude to the agent who sold me my Life Insurance policy.' "

But the assurance of an income in those years at the close of her career is just one of the things a Life Insurance policy will do for the graduate nurse. The nature of her work—the long hours and heavy cases—tend to break down her health, sometimes so completely that, while perhaps still in her youth, she is never able to work again. A self-supporting woman realises very acutely what total and permanent disability would mean to her, and there is no woman who knows better than the trained nurse the cost of doctor's bills, drugs, and all those little extras incident to illness. The small savings are soon exhausted, and she is faced with the possibility of becoming a burden on her relatives, or a ward of charity. A woman's inherent pride makes her dread the thought of dependency, especially a dependency encumbered with doctor's bills and possibly undertaker's expenses.

Several years ago I sold a $5,000 Endowment policy to a friend of mine, a graduate of one of the —— hospitals. I had particular difficulty in getting her to accept the disability provision, for she had never known a day's illness, and didn't realise what a serious illness would mean to her. However, I finally persuaded her to do as I wished, and as she signed the application she laughingly said, "Whether this disability will ever do me any good or not, I don't suppose I will ever miss the little it is costing me each year for I would throw away more than that in trifles."

About six months later my friend was driving on the highway and her car was side-swiped into the ditch. She miraculously escaped without a scratch but the shock in some way injured a nerve so that she has been unable to walk since. The doctors say she may recover, how soon, they cannot tell. When I went to see her shortly after the accident she greeted me with a smile. "I can't thank you enough for having induced me to take out that disability protection. While the $50.00 I am receiving from it isn't such a great deal, along with what I had saved, it has kept me from a charity ward in the hospital. I don't think I could have stood that."

The total disability provision in a policy specifies that if, before his sixtieth birthday, the insured should become so disabled as to be unable to carry on his profession for three consecutive months, the company will pay him a sum each month equal to 1% of the amount of his policy, as long as he remains disabled. Besides this, all the premiums falling due on the policy during this total disability are paid by the company. Whether the insured recovers or not, no deduction will be made from the amount of the policy for the payments which have been made to him.

You need only speak to those who carry this form of protection to realise what a load of anxiety it lifts off one's mind.

Many women are under the impression that since they intend being married at some time they have no need for insurance. I was once trying to sell a policy to a young woman, an interior decorator by profession. She listened rather smilingly for a few minutes before she asked, "But supposing I cheat the Old Ladies' Home by getting married instead of by taking Life Insurance?" Her triumphant look showed that she thought as we say "she had me there." In a very few minutes I had her convinced that the maturity value of a policy is as useful to a woman after she is married as if she had remained single. Too often the death of a husband who was either under-insured or could not obtain insurance has left a woman to her own resources. I reminded this young woman that after ten or twenty years of married life she could no longer expect to obtain the work or command the salary she formerly did. The older women's places are constantly being filled by their younger sisters.

I also pointed out that the proceeds of a mother's policy will help provide a university education for the children which they may never obtain otherwise. Too, in many cases a woman's policy has matured at the turning point of a husband's career, when financial assistance was doubly welcomed. Rightfully proud is the woman who has been a factor in her husband's success.

Occasionally, for one reason or another, a woman must obtain money without delay. There is no security on which a bank is more willing to loan money than on a Life Insurance policy.

There are very few who are unfamiliar with one of the chief functions of Life Insurance—the protection of one's dependents. We have mentioned that many professional women are the sole support of their parents. What would happen to these dependents should the source of their support suddenly be cut off? If she were insured under a Life Insurance policy for the benefit of these dependents the proceeds of the policy would immediately be paid over to the beneficiaries as a continuance of the daughter's income. We don't like to think of what would happen to the dependents of a daughter who neglected to insure herself against such a contingency. In what better way can we show our love for those who have done so much for us than by providing for them in case we will not be able to do it personally?

Life Insurance is the greatest all-round protection society has ever known. It supplies for the needs of men, self-supporting women, wives, widows, children, and dependents.

There is no substitute for Life Insurance. Once a woman realizes what it will do for her she no longer hesitates in securing its services. It is the duty of the older nurses who have experienced the brevity of the working life of the members of their profession to do everything in their power to start the younger nurses thinking of the years to come and of the necessity of making provision for them immediately. The working period of any woman's life is almost too short to provide a worth-while superannuation fund, and every wasted year means a that much smaller fund. You nurses who are just entering on your careers, don't let time cheat you in this way!

Another thing to be borne in mind is that one's insurability varies with one's health. A nurse may be an excellent insurance risk at the present, and two or three years from now unable to obtain insurance at all. Insurance companies are constantly called upon to pay claims on the lives of people who just a few weeks or months previous were considered excellent risks. Don't pass up your opportunity. Insure while you can!

If you are alive tomorrow and uninsurable you will be facing the dreary possibility of a future without a definite income. If you are alive and uninsured twenty years from now you will in all probability be entering into the closing years of your life with financial anxiety or dependency as your companion, leading the way to a realm of worry and regret. Don't let that happen!

A Study of Nursing in England

An interesting announcement has just appeared in the English press to the effect that a study of nursing is being undertaken in that country. It is a medical journal, viz., *The Lancet*, which is providing the initiative in the matter. In the issue of November 8th this journal made a brief announcement concerning the proposed study, and this was followed a week later with an extremely interesting explanation of the proposed work. A Commission of Inquiry has been appointed and the following names are given as members who have already consented to act: Miss R. E. Darbyshire, Matron, University College Hospital; Miss L. Clark, Matron, Whipps Cross Hospital; Professor Henry Clay, late Professor of Social Economics of the University of Manchester; Professor F. R. Fraser, Professor of Medicine in the University of London; Dr. Robert Hutchison, Physician to the London Hospital; Mr. A. Lister Harrison, chairman, Committee of Management, Metropolitan Hospital; Miss M. D. Brock, headmistress, the Mary Datchelor Girls' School; Mrs. Oliver Strachey, chairman, Employments Committee, London Society for Women's Service; Miss Edith Thompson, member of council, Bedford College, University of London; Sir Squire Sprigge, the Editor of *The Lancet*; with Dr. M. H. Kettle, an assistant editor, as honorary secretary.

Thus we find that studies of nursing education and nursing service will now be proceeding simultaneously in England, in the United States and in Canada. Doubtless each will proceed along characteristic lines and thus a variety of method and interest will be brought to bear upon these professional problems. All of this should produce very useful results.

Editorial

Peace

The suggestion has been made through the *International Nursing Review* that national nursing journals should call the attention of their readers to a disarmament petition drafted by a small committee of prominent persons in different countries following the 1929 meeting of the Women's International League for Peace and Freedom, held in Prague.

The petition reads as follows:

> "The undersigned men and women, irrespective of party, are convinced:
>
> "That the present policy of armaments renders further wars inevitable;
>
> "That wars will in future be wars of extermination;
>
> "That the Governments' assurances of peaceful policy will be valueless so long as those measures of disarmament are delayed which should be the first result of the Pact for the Renunciation of War.
>
> "They therefore demand total and universal disarmament and request their Government formally to instruct its delegates to the next Disarmament Conference to examine all proposals for disarmament that have been or may be made, and to take the necessary steps to achieve disarmament."

It is doubtful if Canadian nurses will be in complete sympathy with the terms of this petition, but unquestionably the ultimate aim of peace is fervently desired by every one of them.

There are different methods of arriving at desired results. Two of the best known of these are legislation and education. Legislation is something imposed on people, but education leads them to want the desired object. Legislation may give quick results, or it may be completely sterile. Education is a longer but surer process. Sir Rabindranoth Tagore, the great poet and mystic of India, says "Education will solve world troubles," and H. G. Wells, in his incisive and dramatic way, declares that civilisation is a race between education and catastrophe. Our job is to determine the basis of an educational programme which may avert this catastrophe.

In order to make an educational programme for international friendliness really effective, we must begin with children, for as Plato said, "that is the time when any impression which you may wish to communicate is most readily stamped and taken." And we must make sure of our methods. Preaching to children about the need of loving people of whom they know little or nothing is apt to be quite futile. But if you can devise a bond of real comradeship such, for instance, as there is in Junior Red Cross, international friendliness will naturally develop without any perfervid oratory on its behalf. In Junior Red Cross there are common purposes which are carried into effect in much the same way, no matter what variations there may be in race, religion and language. These purposes—the promotion of health and the promotion of unselfish service for others—have a universal significance, and judging by the phenomenal growth of the organisation in its ten years of existence, they are filling a universal need.

Children in one country watch with interest what their Junior comrades in other countries are doing. Reports of activities are published in their national magazines. In order to allow for expression of this spirit of comradeship, the Junior Red Cross, through its national and international offices, gives the opportunity to branches to participate in the scheme of international correspondence. Last year in Canada we sent out 245 albums of correspondence to the following countries: Alaska, Argentine, Australia, Austria, Belgium, Bulgaria, China, Czechoslovakia, Denmark, Esthonia, Finland, France, Great Britain, Holland, Hungary, India, Ireland, Italy, Japan, Latvia, New Zealand, Norway, Poland, Roumania, South Africa, Spain, Sweden, Switzerland and the United States, and we received approximately the same number in return. Through this intimate correspondence, children are learning the ideas, customs and tastes of the children with whom they correspond more effectively than they could ever do through the printed pages of a book. Nations are coming to mean, not geography lessons with long lists of exports and imports to be learned, not theatres of war and threats of war, but the homes of other children whom we have almost met and have begun to understand. As Sir Phillip Gibbs says in his book, "The People of Destiny": "The front door of any little school which has membership in the Junior Red Cross opens to the wide world and the spirit of the school is directly in touch with the children of many countries."

The members of the medical and nursing professions have a greater opportunity and therefore a greater obligation than others in breaking down the barriers of antagonism that divide the nations. The scheme of the exchange of nurses which is now being worked out by a committee of The Canadian Nurses Association ought, in time, to contribute greatly to international understanding and goodwill.

Dr. A. V. Hill, Foulerton Research Professor of the Royal Society, London, England, sums up in the following statement the case for the opportunity shared by the medical and nursing professions in the great work of bringing about a state of national morality which would regard war as beyond the bounds of decency:

> "I believe that the pursuit of knowledge, for the welfare of the race, is one of the greatest agents of good-will between men in every land. Our theories may be wrong—which does not matter much—our observations may not prove accurate enough—which is bad—our experiments partial and misleading—which is awful; but the fact that we have marched side by side in an honest endeavour to conquer ignorance, that we have sailed the unknown seas together in search of adventure and truth, and that we have learned to understand and love one another not only as fellow-workers but as fellow-beings—these things cannot fail to draw us together and so to minister to the welfare and comradeship of the different varieties of men. Such at least is my firm faith. I see in science and medicine more hope of co-operation between the nations than in any other field of human endeavour."

The means of disseminating goodwill such as we have mentioned will, in the opinion of the writer, usher in an era where war between nations will be an impossibility. But this method demands patience, faith and unceasing work on the part of every one; it means much greater effort than the signing of a document.

J. E. B.

Man is an instrument over which a series of external and internal impressions are driven like alternations of an ever-changing wind over an Aeolian lyre, which move it by their motion to ever-changing melody.

—Shelley in Defence of Poetry.

Sophie Mannerheim

ABSTRACTS FROM A MEMOIR

By BERTHA EDELFELT

Few people of her distinction have been as unassuming as Sophie Mannerheim, though it would be difficult to find any name more worthy to appear in the Finnish peerage, if the word "peer" be taken in its highest sense of a refinement which is the product of centuries of cultivation and long years of inherited culture, both of mind and body. Her whole gracious presence, her finely-shaped head, so proudly set upon her shoulders, her fine carriage, the soft, clear tones of her voice, every physical characteristic was but the outer harmonious expression of her spiritual qualities, warmheartedness, courage, generosity and a noble breadth of vision—everything, in short, that is meant by breeding . . . St. Martin won his sainthood by giving half his cloak to a beggar. Sophie Mannerheim would have given not only the whole cloak, but all her worldly possessions and her throbbing, loving heart, the peace of her nights and the calm of her days if anyone were in need. When she came upon some tragic incident in life, she never said, "How terrible to see so much distress," without adding immediately, "What can be done to help? What can I do?" And in the same instant a plan was ready and in the next it was carried into effect, and very often help found. Circumstances brought her into contact with literally thousands of people of all ranks, many of whom she came to know intimately.

Eva Charlotta Lovisa Sofie Mannerheim, daughter of Count Carl Robert Mannerheim and his wife Helene, née von Julin, was born on December 21st, 1863, in Helsingfors, but spent her childhood on the family estate Willnas, in the west of Finland . . . When she was 22 Sophie Mannerheim came back to Finland. It was at the time when Ibsen and Kielland were at the height of their fame. The old ideas were tottering and girls belonging to the highest families in the land were going out into the world, if not like Nora to educate themselves, at any rate to carve out an independent career. It caused a certain amount of sensation when Count Mannerheim's daughter took a post first in the Statistical Department of the Customs Office, and later as cashier in a large bank. But emancipation was in the air and even the older generation admitted that she had courage and Sophie Mannerheim soon found a host of admiring friends among her fellow-workers, while her capability won for her the unreserved respect of her chiefs.

When she left the bank she travelled abroad with Mrs. Karamsin, wife of Colonel Karamsin, a relation and old friend of the family, visiting relatives so far distant as in Portugal and spending a season in Berlin, where she found more friends and other members of the family in diplomatic circles, who were delighted to receive her. She then came home and married Sir (Kammerherre) Hjalmar Linder, and went to live on the beautiful old estate of Laxpojo, her new home. But after a few years, the marriage was dissolved and the day in the spring of 1899, when Sophie Mannerheim entered St. Thomas's Hospital, London, as a student nurse was probably the turning point in her life.

Her extraordinary capacity for work which could only partly be satisfied either in the routine of cash and figures or in an uneventful country life, now found full scope . . . She had at last found the work she desired, not for money or for her own sake, but for others, work into which she could put her whole heart and soul. Here on every hand were people who needed her, whose lives could be brightened by her ministering hands and boundless enthusiasm. Here was a world of which she had barely dreamed, stretching out its arms to her, amply repaying her the love she poured out upon it. Here was her place; she felt she had found her mission in life.

In 1902 she came home to Finland, lived for a little while in Borga, served as a nurse in the Hogsands sanatorium for scrofulous children in the summer of 1903, and in 1904, with much hesitation, became matron at the Surgical Hospital in Helsingfors.

When she started her duties, she found that compared with St. Thomas's Hospital, much of the administration and organisation was unsatisfactory and out of date, and in her eager enthusiasm at once wanted to institute sweeping reforms. She encountered considerable opposition but was able on most points to overcome it. The old system of a one year's course of training for nurses was gradually extended to a three years' course with a four months' preparatory course and a carefully thought out curriculum for the practical and theoretical instruction; night duty was systematically arranged, more staff was provided in the wards, the nurses' living conditions were improved, and salaries and pensions were raised. The long-cherished hope that it might one day be possible to organise courses of instruction for patients who had to spend a long time in the hospital, technical subjects for adults and school subjects for children, was at last realised as the result of Sophie Mannerheim's energy and generosity (she defrayed the expenses of the first courses from her own pocket) . . .

Sophie Mannerheim's sphere of activity continued to extend like the ever-broadening, ever-multiplying circles on the water where a stone has been cast. It was now not the Surgical Hospital alone, though it had always a special place in her heart, that took her time and energy. There was the students' home and school of nursing, the convalescent home and the holiday home for nurses, the so-called Red Hut, that she had instituted, and the nurses' journal "Epione" was published through her initiative. She had occasionally taken part in congresses in foreign countries, and as an indirect result the nurses' association became a member of the International Council of Nurses and sent representatives to conferences in different parts of Europe and even to America. Sophie Mannerheim continued to take part in these meetings and her name became more and more known, and the force of her personality was increasingly felt. Out in the world she began to be regarded as a force to be reckoned with and an intelligence that could not be done without. Her advice was sought everywhere. Her correspondence covered the whole civilised world and of late years she travelled extensively in the interests of nursing, even visiting the Balkans and Greece. She was elected President of the International Council of Nurses for the three year period 1922-1925, and thus became the head of all the nurses' associations in the world; at the end of this period the International Council of Nurses met in Helsingfors and Sophie Mannerheim had achieved her end. Finland became widely known when the thousand nurses went back to their respective countries full of admiration for Finnish culture and the beauty of a Finnish summer . . .

Sophie Mannerheim had the good fortune to see the fruits of much of her work during her lifetime. Honours were showered upon her; she received the Florence Nightingale medal and also Finland's White Rose. She was President of the International Council of Nurses and Chairman of the Advisory Committee on Nursing of the League of Red Cross Societies. She was further honoured by a request to set up a school of nursing in Paris entirely upon her own lines. Unlimited funds had been promised from America for this great undertaking which aroused her deepest interest, but which unfortunately was never carried out because she became seriously ill and the whole plan had been based exclusively upon confidence in her ability and personality. It was a great disappointment to her to be obliged to refuse and she often thought regretfully, during her last illness, of what might have been done. Here in Finland she was made an honorary member of General Mannerheim's League of Child Welfare and a member of the State Child Welfare Committee.

No other woman in our country has won such general esteem and such high honours. But Sophie Mannerheim thought little of her own worth. She knew that much still remained to be done, that the struggle for her ideals was becoming more difficult year by year on account of the changing conditions in the country after the war. But she was undaunted, she had more than enough moral courage and was ever ready to fling herself into the breach in case of need. She knew no fear.

She had many opportunities in her life of showing that she had this unbounded moral courage, the hallmark of breeding, and she also showed great physical courage during the two long and severe illnesses, which one after the other finally wore away her strength so that on January 9th, 1928, she bade farewell to the life she had so much loved, life in the service of humanity.

Our art of living, when we achieve it, is of so high and fine a quality precisely because it so largely lies in harmoniously weaving into the texture elements that we have not ourselves chosen, or that having chosen, we cannot throw aside.—Havelock Ellis.

Institute of Public Health
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Hospital Administration

By SISTER MARY of the SACRED HEART, Superintendent, Hotel Dieu Hospital, Chatham, N.B.

Hospital service today, like medicine, is rapidly becoming a more and more complicated science, requiring not only adequate accommodation but intricate equipment, highly trained personnel, and more scientific procedures and technique. The administrator of such an institution is involved in a business greater than all others, for human life is the commodity with which she must deal. I take it for granted, of course, that the superintendent is a nurse, for in almost all our New Brunswick hospitals the superintendent is a woman. The burden of administration might well find a more substantial support on male shoulders, but it is a question if all the minor details, so difficult of accomplishment, would meet as nice an adjustment at the hands of a man.

We, who know the inner workings of the hospital, realise keenly its manifold difficulties. The problems of the large hospital differ somewhat from those of the smaller, but possibly only in quantity. The elements which go to make for efficiency differ not at all. The administration of a hospital, then, is becoming more and more difficult as requirements are increased, and it is on the shoulders of the superintendent that the burden weighs heaviest. Practically, the supervision and management of the hospital devolve on her. Her duties, particularly from the standpoint of supervision, are manifold. Her charge demands a knowledge of the working of the entire institution. The purchasing of general supplies and equipment, and the dispensing of supplies to the various departments, come under her care. In addition, she must be constantly in touch with all the departments, from the office, dealing with the admission of patients, on through the various floors, operating rooms and other departments, acting always in an advisory capacity, making certain that existing regulations are fulfilled, and that the general progress and daily routine are up to the standard requirements. It has been well said that the most successful executive is he who can wisely delegate work to others and have it well done. Doubtless it is a mark of leadership, a quality very essential to this office. The superintendent must have the loyal support and perfect cooperation of all department heads: the director of nurses, floor and surgical supervisors, pharmicists, dietitians, as well as the entire office staff. A very effective way of ensuring this co-operation is the weekly conference of the nursing staff, at which general information is given, correspondence read, and mistakes or omissions tactfully set right. These meetings, conducted in a kind, informal manner, preserve and strengthen union among the different members of the staff.

Care of the physical plant is a matter of difficult accomplishment due to the very general problem of hired help. The strictest economy needs to be practised in the use of all hospital property, but where repairs are needed the best economy is to have the work done at once and by as expert a workman as it is possible to secure. Economy may be practised in every department without in the least degree impairing the general helpfulness of the branch of material welfare

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(A paper read by Sister Kenny at the Annual Convention of the New Brunswick Hospital Association, held in Moncton on September 30, 1930.)

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involved. The reputation of many a hospital has suffered because of a false economy, and this is nowhere to be so much deplored as when applied to the diet and setting up of patients' trays—a subject that brings up in sad array too many instances of not heeding the fact that it is indeed the little things which count.

The methods of handling accounts should follow precisely the system employed by any well organised business concern. The perpetual inventory, the daily check upon expenses and receipts, and the monthly tabulation of each department's expenses, are perhaps the basic factors in the proper and efficient administration of a hospital. But the welfare of the hospital is not necessarily widened by a low per diem cost. A modern hospital is not only a place where the sick are treated, but fundamentally a health centre where all the latest hygienic, sanitary, medical and surgical discoveries made the world over are at once brought to the service of the community. Such advancements in science cannot be provided without therapeutic measures which are authoritatively recommended to the treatment of diseases, the most modern improved equipment for all the special laboratories, and the most modern labour-saving devices which can be utilised in hospital work. Such obviously are necessary in the proper care of the patient if the hospital is to serve its best interest in the community.

Thus we see that the cost of taking care of a patient in such a hospital will be high. Our endeavour should be to provide good service, comprehensively viewing every department to eliminate even the slightest useless expenditure, confident that every patient, whether free or pay, is being accorded his indisputable right to profit by all scientific achievements. When all is said relative to good buildings, excellent equipment, careful upkeep, daily and hourly supervision, the best of domestic economy and all that makes for that eternal vigilance said to be the price of success, one thing alone stands out for the welfare of any institution, and that is hearty co-operation on the part of those interested in its welfare.

If it is true that a human being is valuable in proportion as he proves himself able and willing to co-operate with his fellowmen, in no sense is it more true than in working for the welfare of such an institution as a hospital, where ideal conditions become possible only when all engaged in the service of suffering humanity admit the need of working shoulder to shoulder. Let the chief of staff and the superintendent feel not too important, nor the orderly or fireman too unimportant, but let one and all realise that the material welfare depends largely upon individual responsibility in a given charge. Only by the practical realisation of these facts will the hospital be well administered and its welfare best promoted.

The duty of doing, not great things, but what we can is the very top and sum of human obligation.—J. F. Ware.

History of the Thermometer and Its Use

By HEBER C. JAMIESON, M.D., Professor of the History of Medicine and Associate Professor of Medicine, University of Alberta, Edmonton

What would happen if a hospital found itself without a clinical thermometer? How did doctors and nurses ever get along without it? Who invented this instrument? and when was it first used clinically? These and many other questions may enter the inquiring mind. Answers can be found for all of them, and they form a most interesting history of the thermometer and its use in daily hospital routine.

The ancient Greeks believed that the world was made of fire, air, earth and water. These four elements also went into the composition of man and being mixed in varying quantities, gave different constitutions to individuals. Into the arteries went the air or spirits. The blood was red like fire and contained some of this element. The organs such as the liver and the muscles formed the solid parts which had a larger portion of earth.

Galen, one of the greatest of early physicians, taught that there were three kinds of fever. The first occurred in the spirits and in this fever the heat was not offensive on the first application of the fingers to the skin, but conveyed an acid sensation after a short time.

The second form of fever originated in the fluids such as the blood, and on laying the hand on the body it was first met by a strong and pungent heat, which seemed as if carried upwards in the form of a vapour, but was soon extinguished under the hand if it was allowed to remain.

In the third class of fever, of which the hectic is an example, the heat on the first application of the hand seemed faint, but soon afterwards felt acid and pungent.

In medieval days the hand was used as a thermometer to detect fever and estimate its height, but not uncommonly the foot was employed in taking the temperature of the baby's bath.

The first person to recognise the fact that the human body had a normal and fairly constant temperature was Sanctorius. He devised a thermometer which was very crude and inaccurate. In one of his instruments the bulb was placed in the mouth and a long S-shaped tube which was divided into degrees hung down almost to the waist. The thermometer remained in place during "ten pulse-beats" and then the temperature was read.

Sanctorius was so convinced of the precision of his instrument that he attempted to estimate the heat given off by the moon some 200,000 miles away. One of his thermoscopes, as he sometimes called them, and its use, he describes in a letter written in January, 1632:

"I observe there are divers kinds of thermoscopes and thermometers; what you tell me does not agree with mine, which is merely a small round flask having a very long slender neck. To make use of it, I put it in the sun, and sometimes in the hand of a fever patient, having filled it quite full of water except the neck; the heat expanding the water makes it ascend by a greater or less amount according to the great or little heat."

Shortly after this, Delane, an Italian, devised thermometers of glass bulbs in the form of turtles which could be applied to the arms and body of a fever patient. These were filled with wine or coloured alcohol. This was considered the ideal substance for this purpose, but we have Delane remarking: "Some curious people use mercury in thermometers."

Some of the early thermometers were graduated or at least roughly divided into spaces. Delane suggested that the freezing point of water be marked "cold" and the boiling point of butter be marked "hot".

The first really reliable thermometer was constructed by Fahrenheit about 1700. He found that when he immersed his instrument in water and ice the liquid stood at 32°. This he called the freezing point. His second temperature of importance was 96°. This he found to be the mouth temperature of a healthy man. Today we have adopted the Fahrenheit scale, but place the human normal temperature between 98° and 99°. To show how little was known about the temperature in fever at the commencement of the 18th century one has only to read Fahrenheit's own words:

"If, however, the temperature of a person suffering from fever or some other disease is to be taken, another thermometer must be used having a scale lengthened to 128 or 132 degrees. Whether these degrees are high enough for the hottest fevers I have not examined. I do not think, however, that the degrees named will ever be exceeded in any fever."

It took over 100 years for the thermometer to be recognised generally as of value in fever. Chomel, the foremost physician in France, writing in 1834, laid great stress upon temperature, but believed the hand to be the only proper instrument to determine it, and that the thermometer only gave imperfect ideas of its elevation, and was unable to give any indications of its special modifications.

The inaccuracies of the thermometer and the lack of knowledge of human temperatures in health and disease were responsible to a large extent for its slow adoption by the medical profession.

Piorry, in 1838, speaks very highly of it, but records temperatures of 110° and even 117° Fahr.

The thermometer was the first instrument of precision made available to the medical man. The stethoscope preceded it in medical practice, but what one man heard might differ from what another heard in the same case, and the interpretations might be wide apart. With the thermometer a result was obtained that could be measured and expressed in figures and these were physically accurate.

Wunderlich, writing in 1868, said that it was quite enough to have one accurate thermometer in a hospital. All temperatures taken with various instruments had to be corrected.

The directions for taking temperatures as set down by Wunderlich are of interest. The well-closed axilla is the place of choice for this purpose. He believed that the mouth was unsuitable because the results were uncertain. And besides, the cool air inspired might lower the temperature.

Taking temperatures by rectum he condemned thus: "Taking the temperature in the rectum, so warmly advocated by many observers, is repulsive, can seldom be repeated often enough to satisfy the exigencies of the case, may provoke the action of the bowels, and perhaps produce prejudicial chills by the necessary exposure."

He condemns the method of holding the instrument in the fist, but says that putting it in the clefts of the fingers or toes may be used in special cases.

The thermometer was left in the axilla from ten to twenty minutes or longer and when a record was made it was necessary to note the day of the month and the time of the day or the whole of the observations would be useless.

The German physician, Wunderlich, would not trust anyone to take temperatures. Here is what he says: "Any trustworthy, honest, and intelligent man, with a good sharp sight, or provided with spectacles if necessary, can be very quickly taught to take temperatures with sufficient accuracy."

In the wards of the large hospitals certain methods were to be followed. Before the doctor entered, a thermometer was placed in the axilla of every patient. He would go around quickly and see that they were properly adjusted. After about twenty minutes the "trustworthy, honest, and intelligent man", perhaps with "spectacles," went around and read the temperatures, but being careful not to disturb the instrument, for the doctor himself had to confirm his readings. In this way the temperatures of twenty patients could be obtained in less than an hour.

One reason for reading the thermometers while still in place was due to the fact that in the type used until quite recent years there was no special valve to retain the mercury at its height until shaken down. In consequence of this the temperature would have dropped several degrees while the thermometer was being taken out and inspected. The instrument was from five to ten inches long, which facilitated its examination when in place. In the early days of medical thermometry slight variations of temperature were not thought of great significance, because of the uncertainty of the instrument. Today this instrument of precision gives most accurate readings, and the records of up-to-date hospitals are accepted by all as being reasonably correct.

One wonders with what accuracy Sairy Gamp, or her bosom friend and associate nurse, Betsey Prig, would record temperatures. When Sairy was taking over night duty from Betsey during the illness of Martin Chuzzlewit, she gave instructions for her night lunch to the maid:

"If they draws the Brighton Old Tipper here, I takes that ale at night, my love; it bein' considered wakeful by the doctors. And whatever you do, young woman, don't bring more than a shilling's-worth of gin-and-water warm when I rings the bell a second time."

Is it any wonder that the use of the thermometer in the hands of any but well-trained observers fell into disuse?

The revolution in medical skill and the brilliant work of Florence Nightingale advanced hospital practice to a point where the well-trained, highly-educated and capable nurse of today, tripping about the wards taking temperatures with accurate instruments, records figures which can be relied upon.

The curious and clumsy toy of the 17th century has become an indispensable scientific instrument in modern medicine.

Typhus Fever

By **JANET L. BRYDON**, Hwaiking, Honan, China

Typhus, or famine, fever is known as a dread disease that visits soldiers' camps and regions of famine and poverty. During the last few years there has been much of it in the North-Central provinces of China.

In these provinces, where foreigners have gone to give famine relief, as a first precautionary measure it has been advisable to institute on a large scale some method of disinfecting refugees and their clothing. During the famine of 1920, temporary huts were erected and arrangements made for each person to be given a bath, while in another room their clothing was disinfected and made ready to be used immediately after the bath was completed. Garments of special design and quality were provided for the workers, leather being largely used. Where these garments were not available, tight bands and coal oil on wrists and ankles afforded some protection against the louse.

Instead of infection being carried by the bite of the louse, it has now been ascertained that often it is by the faeces of the crushed louse being rubbed into the skin by scratching. The period of incubation is from four to twelve days. The disease first manifests itself by debility and headache, with a temperature rising on the third day to possibly 103 degrees, gradually increasing, sometimes to 106 degrees. The patient may be delirious or lie in a state of unconsciousness, with low mutterings, for days. The tongue becomes very parched and often cracked. The skin, too, is dry, and great care is needed to prevent bedsores. The urine is scanty, highly coloured, and retention is very common. Soldiers and refugees who have not proper nursing care often suffer very greatly from this cause.

The heart must be carefully watched, death often resulting from heart failure during the second week. Nourishing liquid diet is very important to maintain the strength of the patient. Convalescence is usually quite rapid, but rest for some months afterwards is recommended.

The percentage of Chinese recovering from typhus is much in excess of that of foreigners in the country. At one time it was considered very rare for one from a Western country to recover. Last year, within a few months, one small mission in Shensi lost three of its staff.

With only one outfit of clothing for the private soldier, a lack of facilities for cleanliness in their ranks, and the low standard of living among the poor of the country, the stamping out of typhus means a colossal task. While war and poverty continue to rank as two of China's greatest enemies, typhus is bound to persist as a menace.

Mothercraft Established in Toronto—"Keep Well Babies Well"

Readers of "The Canadian Nurse" will be interested to know that a movement in connection with the care of infants is well advanced in Toronto, sponsored by the Hospital for Sick Children. Throughout the Province of Ontario and into its sister Provinces it is hoped the work will soon extend.

Miss Helen C. Satchell, formerly assistant to the Matron at the Mothercraft Centre, Highgate, London, England, arrived in Canada in November to head the projected pioneer centre in Toronto. She comes with highest qualifications. A graduate of the General Hospital, Christchurch, New Zealand, she later engaged in private nursing in Dunedin. While there she took complete training in Mothercraft and for a year thereafter engaged in district work under the Plunket system. Subsequently she qualified for her midwifery certificate.

It is believed that there is a distinct need in Canada for graduate nurses who are specially trained in the care of mothers and newly-born infants, and it is, therefore, proposed to introduce a post-graduate course for trained nurses, graduates of any recognised hospital, the course to be an intensive one, covering a period of from four months, and designed to fit the nurse for this special work, to be carried on either under governmental auspices or in the course of private duty.

Natural feeding will be stressed, for, tubercular mothers excepted, it has been proven on the highest authority that there is no valid reason why women cannot feed their children naturally, that is if they receive proper treatment and instruction.

The right of every child to a fair start in life is becoming more and more emphasized, and therefore, the plan of education in Mothercraft which in the course of a few weeks will take effect in Toronto is being welcomed by all interested in child welfare.

What the Mothercraft Centre which the Hospital for Sick Children proposes inaugurating at its Cottage Hospital at 84 Wellesley Street, Toronto, may mean to mothers, more especially young mothers facing with trepidation the physical care of their babies themselves, is a matter for interesting and hopeful conjecture.

The Dominion, so forward looking in many respects in regard to public welfare, has rather lagged behind in its consideration in concrete terms of the problem of infant mortality, in which New Zealand has made in these past years such inspired experimentation: an experimentation which has resulted in magnificent achievement.

Since the work began in New Zealand twenty-two years ago the Plunket system has continuously lowered the infant mortality rate in producing healthier babies. In the last eight years the infant mortality rate has been lowered from 47.4 to 34.10. Her Antipodean neighbour, Australia, has followed in her footsteps. The Mothercraft movement has spread to South Africa. Japan, so keenly alive to the advantages offered by Occidental scientific achievement, has become interested, and in Palestine, also, the movement has taken hold.

It has been stated that the temperate climate and good conditions generally prevailing in New Zealand had much to do with the success of the movement. It is well known, however, that that country had a climate as good, if not better, and conditions for rearing infants were better when the Plunket Society, as it is familiarly known, was established, than at the present time.

MOTHERCRAFT CENTRE, TORONTO—FORMER COTTAGE HOSPITAL
84 Wellesley Street

Institute of Public Health
Faculty of Public Health of the
University of Western Ontario
LONDON : CANADA

"Keep Well Babies Well"

This has been the watchword of the famed Plunket Society through the years of its phenomenal growth in the land of its inception and in the countries which have since taken it up. The four words briefly and concisely sum up the whole aim and teaching of the movement, which is now being launched in Canada—in Toronto, through the Hospital for Sick Children.

It is very fitting that the great institution on College Street, and now also at Thistletown, which has been the Mecca of medical men and surgeons from all quarters of the globe, should give initiation to a system of training for mothers—and the nurses who will guide these mothers, which, simplicity in itself, will nevertheless do a tremendous good in preventing disease and disability in the rising generations.

From the dollars-and-cents point of view merely, the plan of mothercraft teaching, which is now being worked out, will mean a very appreciable saving in the financing of the country. What it will mean in the lives and happiness of the children of the Dominion, and in the lives of their parents is a matter of far greater moment.

The plan of Mothercraft which is about to be put into practical effect, is not a system completely lifted from some other country with its own peculiar conditions. This movement, while it will adopt the salient features of a system of preventive work which has been put into operation in so many parts of the world already, will develop along lines which will to the very greatest degree make it appropriate to Canada, with her own problems, social, economic and geographical.

Many eminent medical men of the community are whole-heartedly in sympathy with the movement. The pitiful and unnecessary waste of human life due to lack of intelligent care on the part of parents in the early stages of life has been all too apparent to them.

There is an old saying, which, as a saying may have become a bit old-fashioned, but the principle of which is as true today as it ever was: An ounce of prevention is worth a pound of cure. Mothercraft teaching has again proved the validity of the old saw.

Again and again surgeons and medical men accomplishing miracles in the healing of bodies broken in health, have at the same time had reason to deplore as needless much of the suffering which they bend their energies to alleviate.

Now comes this plan of Mothercraft, so simple in its principles, so essentially sane, to do its part in the upbuilding of infant health with all its implications.

There are critics of the movement as there always have been critics of movements, but those who have studied the work as it has been carried on elsewhere have found that its success has been phenomenal and so general has been that success, though the countries into which the Mothercraft system, now under consideration, are widely divergent in custom, tradition, climate, that it cannot be regarded as mere chance or accident.

The work is primarily educational and humanitarian, and from first to last its proponents stress breast feeding. Artificial modes of living have made breast feeding seemingly impossible oftentimes, but it has been demonstrated under the present Mothercraft plan that the difficulties in the way of the mother taking natural care of her child, may, to a great degree be overcome.

The Hospital for Sick Children, through its Wellesley Street centre, will supply and maintain an organisation for the giving of instruction. Mothers of every creed and nationality will be welcomed. The poorest mother may come as confidently as the wealthiest, and the wealthiest as the poorest mother.

(Editor's Note.—See also "The Canadian Nurse," May, 1926.

Institute of Public Health
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LONDON - CANADA

A Leper Colony in Natal

By **ELINOR N. WADE**

The chief difference between the Cottage Hospital of Natal, South Africa, and those of other countries is the number of servants we have waiting on us, but these native servants are apparently of little assistance, as nurses here seem to work harder than in other countries where there is a lesser number of servants.

This particular institution is a government hospital. That is, it is administered by the provincial government of Natal and staffed by the Natal Nursing Service, of which I am a temporary member. One half of the hospital is reserved for Europeans and the other half is for natives. All patients pay a ''just'' fee; unless they come in by order of the magistrate as a vagrant. The natives pay about half the fee charged to Europeans.

One sick little native baby we had charge of we placed in a wicker cot and allowed the mother to ''special.'' The mother slept on the stone floor at night, using a brick for a pillow.

Native patients on full diet have their own kind of food—meallies (corn), rice and stews in huge enamel bowls twice a day; but the very sick patients, such as dysenteries, are given fluids the same as are the Europeans. Native orderlies are taught to attend to the native patients under the supervision of the nurses.

The doctor here is the officer for the hospital and also for the Leper Colony thirty miles distant, and he kindly gave us an opportunity to visit this location. The Colony covers several square miles of a beautiful valley. With the exception of the manager's house and the dispensary, in appearance it is much like a huge tribal location of Zulus. Appearing among the banana and pineapple trees are the dome-like huts of the natives, made of grass and looking like a large number of beehives perching on the side of a hill.

Here the lepers live as near as possible a normal life. Some get well naturally; others are treated in the early stages with chalmoogra oil and recover; some get worse; some stay the same for life; while many develop complications, especially a disease resembling syphillis. These are treated with an intravenous injection of N.A.B.—a successor of Salvarson. The patients who are able to do so come to the dispensary for this treatment, which is done by the doctor, assisted by a native dispenser (not a leper), and a native girl with slight leprosy.

The very sick lepers live in a row of huts near the dispensary, called the hospital, and it appeared they are waited on by the less sick lepers. The white marks are very noticeable on the dark skins of the Zulus, but what are even more noticeable are the lepers with withered limbs from which the toes and fingers are gradually disappearing. Another form of leprosy noticed was one which caused the body to shrink in stature and the face to become bulbous.

But in spite of the disease, and the fact that those afflicted are not allowed to leave the location, there was no note of sadness among those segregated there. They have their own corn, pineapples and other fruits, and cows and chickens, and instead of the gloom one would expect to meet, they are a contented and happy group.

Department of Nursing Education

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Correlation in Teaching the Student Nurse

By **SISTER M. A. CHAUVIN**, Superintendent of Nurses, General Hospital, Edmonton, Alberta

Papers have been written and discussion held on the subject of Correlation in Teaching the Student Nurse. It is a problem of the greatest importance and one that needs timely consideration from every angle. The work of the professional nurse is practically the same in all the provinces, and it would seem to be perfectly evident that the training which is to guarantee a certain acceptable measure of competence should follow somewhat similar lines, whether the nurse is trained in Toronto or Vancouver, and whether the training is given in a small or a large hospital.

The education of pupil nurses thus constitutes an ever open question because of its vital importance to the large as well as the small hospital. The point never to be lost sight of is that the patient makes the hospital necessary in any community, and the problem of caring for patients is the first duty of the hospital superintendent. Assigning a student to duty in a ward does not necessarily guarantee an education for her in that kind of work. However, the value of ward experience to a nurse depends on several factors: first, the characteristics of the service itself; second, the ability and attitudes of the student; and third, the influence of those in charge of the student.

It is a principle of education that theory is most effective when given simultaneously with the related practice. Lectures which come before the practical work are often forgotten because they lack the associations and practical application which that experience gives. In some schools of nursing it is impossible to give all the students their lectures while they are receiving their practical work in the wards. Fortunately, however, the majority of schools today are equipped to give their theory and practice simultaneously, thereby helping the student nurse to recall points which might otherwise seem trivial and of no great importance.

The opportunity to correlate theory and practice in ward teaching is unique. Nurses are familiar with the technique of nursing and nursing procedure as previously received in the demonstration room, but they do not always recognise the basic principles underlying it. Application of the principles of materia medica to actual medicine giving, of industrial hygiene to lead poisoning, of cardiac diseases to cardiac nursing, could all be made at the best psychological time, namely, when the student is nursing those patients. Ward clinics of interesting cases conducted by the attending physician will give the student nurse a broader view and more scientific understanding, which perhaps would not be received by theory alone.

Superintendents, instructors, and floor supervisors should have special training: they must be executives and teachers as well as nurses. Especially is this necessary on the floors and in the wards. It is necessary that the floor supervisors be able to go into the ward with the student nurse, explaining in a concise manner the practical procedure and giving moral support in order to overcome the timidity of one who is perhaps for the first time giving some special treatment. The demonstration-room classes cannot give the confidence which is needed when the student nurse is asked to do the same on the floor or in the wards.

We are all acquainted with the medical students who come to our hospitals to serve an interneship. When first they are asked to do some practical work in the wards or assist in surgery they are at a loss as to what should be done. They have no confidence because they have had no practical experience. In theory they are good, but what is theory without practical experience?

During the last few years we have read much and heard a great deal of hospital schools of nursing. We have come to realise that nursing is in a very special sense a national service, and that the training of a nurse is a matter of vital importance, not only to her hospital and to herself, but to the country at large. It is not enough that she should serve the needs of a single institution or of a limited group of people. She must be ready to serve the whole community and to meet the conditions as she finds them in many different kinds of communities. The training that can meet the above demands is the training that should be standardised and set up for universal adoption.

The Old and the New in Nursing

By FRANCIS E. WELSH, Supervisor, Isolation Department, Royal Alexandra Hospital, Edmonton, Alberta

Research, progress and advancement along all lines of education, business or labour is the keynote of the present day, and it is only as we compare the older methods with the new that we realise wherein lies the value derived from such progress and what it means to those of us who reap the benefits of pioneer endeavour and foresight. Many methods that were a menace to both nurse and patient in the early days of the present century are now looked upon as improbable and fantastic except by the individual who may have had such an experience.

It is from the viewpoint of humour and not of criticism that the following experiences with nursing problems as they existed in 1900 are given in this article with the hope that they may help some young graduate of 1931 to more fully appreciate the blessings one is apt to ignore.

Away back in 1900 a country school mistress conceived the idea of being a nurse, and at once with high aspirations and unbounded enthusiasm entered a well-equipped, eighty-bed institution, modern in detail and well supplied with everything needful except nurses and maids. There was an adequate number of student nurses, but as the hospital needed funds and these nurses could bring in a revenue of $15.00 a week they were sent out to do special duty in the city or country, to the detriment of the nursing service in the wards.

All service room utensils were copper, and one of the first duties assigned to a new probationer was to scour them with bath-brick until they shone like a mirror, and finger tips were minus nature's covering. The probationer or last nurse answered all call bells and filled all requests, whether it was for a glass of water, the changing of a bed, or getting the patient up for the first time.

Such a thing as a preliminary period was unknown, nor were any other classes or lectures given during the period of training, but student nurses were told that they must read "Hampton." It was not unusual to be awakened at 5 a.m. and told to get up at once and have the bathrooms cleaned before breakfast, as the ward patients would have to be bathed, etc., after that. Without any preliminary preparation and following a single verbal instruction a student might be given the care of a pneumonia case, as well as a rather serious heart case and a medley of other cases as well: but wonderful to relate, nurse and patients survived! There were no floor maids, and supper dishes were never washed until the night nurses came on duty, who relieved the "probie" of answering the bells, and thus she could be spared to do the dishes.

One morning the floor was unusually busy and the night nurse was told she was to remain and help. She was still on duty when word was sent for her to get ready at once and go on a case in the country. No one knew who would take her place at night until at 7 o'clock a nurse was told to report for night duty.

There were neither hours nor half days given. If you wished to leave the building in the evening you obtained permission from the lady superintendent. If you were unable to find her you stayed at home.

One night a very junior nurse who had been in training a month was told to get a comfortable chair and sit by the bedside of a delirious typhoid patient "and get all the rest you can." She had been on duty from 7 a.m. and went on duty next morning as usual, but after dinner she was sent to the main kitchen to rest and peel fruit for preserving.

Another pupil was kept on duty to special a surgical case continuously for two days and a night. On the second night she had two hours off duty and was relieved at the end of the third day, but at 10 p.m. she was sent out to special a case of pneumonia in the city.

Such methods are now obsolete, and it is difficult to believe they ever existed or that anyone would ask for such hours of continuous duty, which in those days resulted in the survival of the fittest. Today facilities for rest and recreation have so greatly improved the morale of student nurses that those of us within whose influence such conditions lie will exert every effort to keep the curve on the upward trend.

Department of Private Duty Nursing

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The Care of the Diabetic Patient

By **FREDERICK W. W. HIPWELL, M.D.**, Toronto

The metabolic disturbance known as Diabetes Mellitis has not yet become the easily explained malady that the discovery of insulin promised. The situation today holds relief for the diabetic, however, in that he has a reasonably good outlook on life, can follow his usual occupations, eat sufficient food to maintain body weight, normal activity and even have some enjoyment in the ingestion of food. If he is a severe or even a moderately severe sufferer, he must of course submit to the inconvenience of one or more doses of insulin daily. Diabetes Mellitis is a profound disturbance of metabolism, affecting not only the mechanism by which we absorb, store and use carbohydrates, but also those processes whereby we utilise proteins and fats. Foods ingested yield chemically carbohydrate, protein and fat from which we obtain calories or heat units necessary for life. Of course we also obtain calories from foods, water, various minerals, salts and vitamines, but these are not within the present discussion.

Digestion of food commences when it is mixed with saliva. Absorption of glucose will take place through the mucous surfaces of the mouth. Products of digestion—glucose, amino acid and fatty acid, enter the blood stream from the intestine through the thoracic duct and are then disposed throughout the body. Here insulin becomes a necessity. Through its action, glucose is stored as glycogen in the liver, heart and muscles —to be liberated later as fuel for the various needs of the body.

Should insulin be less than normal, obviously the normal disposition of food does not take place. There is an accumulation of sugar in the blood and tissues. The liver and other stores of glycogen rapidly lose their natural reserve supplies and we have the wasting of the diabetic explained. There is a demand for more glycogen and the result is the symptom—hunger. We know that body fluids tend to keep soluble solids in solution in a constant amount. With the increase in sugar to be cared for, there is an added demand for water. Thus, there is the thirst and excessive urine. This urine, loaded with sugar —for after the sugar in the blood reaches the level of about 160 mgms, it slops over into the urine—is an irritant to the delicate genital mucous membranes and there is pruritus and even eczema.

Treatment is directed primarily to counteract the faulty process. Food is restricted to conserve the patient's inadequate supply of insulin. But sufficient food must be given to maintain normal body metabolism and usual activity. So when restriction of food alone does not avail, insulin must be given.

Certain food requirements need review. The average proportionate

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(*From the medical service of the Toronto Western Hospital. Read before Private Duty Section of Registered Nurses Association of Ontario, District No. 5, August, 1930.)

adult requires from 25-30 calories per kilogram of body weight per day. He also needs ⅔ to 1 gram protein per kilo. per day. Sufficient carbohydrate must be allowed to ensure an adequate supply of glycogen to the liver, heart and muscles, and at the same time ensure proper utilisation of fat. For the use of fat within the body is dependent in no small measure on the utilisation of carbohydrates.

It is quite optional what method is used in arriving at a diet prescription. I allow 80 to 110 gms. of carbohydrates, 1 gm. protein per kilo. per day and the balance made up from fat. This serves well and can be raised or lowered readily on occasion.

The essential problem of nursing the diabetic patient resolves into general nursing care, the consideration of foods, insulin, and knowledge of the unusual occurrences to be looked for in this particular condition. I cannot stress too much the value of skillful nursing care. More than all else, cheerfulness must be a watchword. These people are prone to depression. Infections are more serious than in others. Cleanliness and comfort is essential. The skin of a diabetic is more likely to break down and add bedsores and burns to an already difficult problem.

Food intake must be measured in some fashion. Scales are best but at least a serious effort should be made to have the meals of today comparable with those of yesterday and tomorrow, and all tally with the figures of the diet prescription.

Analysis of all foods can be obtained. Foods of similar analysis, as much as possible are grouped together. This makes for easy and rapid computation. Foods yielding carboyhdrate are grouped into cereals, fruits and vegetables. Those with comparable yields are put into like classes. Vegetables and fruits are grouped according to their average percentage yield of carbohydrate. For convenience the lower group of vegetables is termed 5 per cent. though for purposes of calculation we use them as 3 per cent.—the average yield of that group. No vegetable in that group yields more than 5 per cent. carbohydrate. The yield of fruits however is higher and here the amount used for calculation compares with the terminology. For example, we speak of lettuce as a 5 per cent. vegetable, while we calculate it as if it contained 3 gms. carbohydrate in 100 gms. Orange, however, listed as a 10 per cent. fruit is calculated to yield 10 grams in 100 grams of fruit, and the peeling is not weighed. Analyses are based on edible portions only. Lean meats do not vary a great deal. Fish contains more water, and proportionately less protein and fat. Of course, if butter or lard are used in cooking, the fat content is increased. Fats in diet are made up to quantity by using butter and cream.

There is no substitute for a carefully calculated and weighed diet. But we will all admit that there are occasions when such is not quite practical. In such cases we must resort to measurements with common household utensils. Even in this way, a fairly accurate diet can be administered.

Insulin as stated previously should be administered when diet regulation alone is sufficient to enable a patient to live his normal life and maintain body weight. Insulin is obtained from beef and pork sweetbreads. It is produced in specialised cells of the gland and is extracted, purified and marketed as a clear fluid in sterilised containers. It comes ordinarily in two strengths—either 20 units per cubic centimetre or 40 units per cubic centimetre. The former has a blue label while the latter carries one of yellow. There is continuously confusion in measuring insulin doses. Remember that the unit of insulin is always the same, only in one case there are 20 while in the other there are 40 in one cubic centimetre of

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fluid. Certainly we do not confuse the number of cents in a dollar, whether it be a paper or silver dollar with which we deal.

In giving insulin it is of prime importance that needles and syringes are in good condition. It is disturbing to say the least to use a dull needle on a patient who may find it necessary to adminster a hypodermic to himself once or more daily for the balance of his days. When the piston of a syringe does not fit tight the insulin will froth in the barrel and accurate measurement is difficult. Alcohol or rubbing alcohol is preferable to iodine for skin sterilisation. Syringes and needles should be boiled. Sterilisation with alcohol is only permissible under unusual circumstances such as during travel, and then the alcohol should be washed out with sterile water. The cap of the insulin container should not be removed, but rather should be pierced with the needle, and should first be wiped off with alcohol.

I like the needle inserted at right angles to the skin surface. The skin should be stretched rather than bunched up. In this way, fewer nerve endings are injured and there is less pain. The point of the needle should be well under the skin but not necessarily into muscle. Massaging is not necessary after adminstration.

Of the unusual happenings liable to occur in the diabetic, we have first diabetic coma or as it is more correctly designated "Keetonic Acidosis." This condition usually is found in patients not using insulin and comes as a result of long continued dietetic upset. An accumulation of poisonous by-products of fat metabolism is responsible. But some of the most severe instances of acidosis occur in insulin patients—even when carefully controlled. Food upset, deliberate or accidental, or infection is responsible.

Acidosis is usually ushered in with increased thirst, drowsiness, headache, nausea and abdominal pain. Consciousness is lost gradually. For some hours the patient can be wakened. Gradually the state of unconsciousness supervenes and the patient breathes deeply and rapidly. The colour is good. Insulin in plentiful doses is the one means of saving the life of the patient. From 100-400 units are given within the first twenty-four hours. Glucose may or may not be used. If the patient is much dehydrated it is possible that normal saline into the tissues will do as much good.

Following recovery from unconsciousness, it is more than probable that there will be no desire for food —or what desire there is will be dependent on a persisting nausea. Mustard paste alternating with an ice bag on the epigastrium will help. Bicarbonate of soda well diluted and in small portions helps a lot. Dry ginger ale or orange juice may be given in small amounts frequently, as much as one to two ounces per hour. An ounce of orange juice per hour for twenty-four hours would give a patient approximately seventy-five grams of carbohydrate—a valuable contribution to a patient suffering from acidosis.

The same plan of feeding, adding weighed or measured quantities of milk and cereal gruels, can be used after a general anaesthetic. These patients all require adequate carbohydrate, from one hundred grams upward daily. The urine should be tested at regular intervals and may serve well as a guide to insulin dosage.

To test urine, to five c.c. Benedict's solution add eight drops of urine. Boil two minutes and no longer. Cool. A change in colour or even cloudiness denotes sugar. Traces of sugar show as a green cloudiness while much sugar is indicated by a total disappearance of the blue colour, the whole solution becoming a brick red.

Insulin overdose is productive of a group of symptoms difficult to classify because of the variation of symptoms. Normally blood sugar ranges from eighty to one hundred and twenty mgms. per one hundred c.c. blood. The blood sugar after food may go as high as one hundred and sixty mgm and still be normal. But it will fall close to one hundred mgms again within two or three hours. Untreated diabetics carry blood sugars as high as four hundred or five hundred mgms, though usually they show about two hundred to two hundred and sixty mgms. Diet may bring a blood sugar within normal range, but diet alone will not cause a blood sugar to fall below normal. Insulin, however, has this property. Blood sugars fall to various low levels incident on insulin overdose. The overdose may be accidental —*and it is well to note here that an overdose of ten units is roughly balanced by the administration of one hundred and fifty grams of orange juice.* As insulin does not produce marked lowering of blood sugar in the first hour, and as orange juice is quickly absorbed, it is well to give the corrective about one hour or a little longer after the insulin has been adminstered. An overdose may also occur incident to natural clinical improvement. The dose for a given patient is not by any means constant and will vary in relation to activity, general health and infection. Insulin reaction, or hypoglycaemia may occur too, as a result of unusual and uneven absorption of insulin or food.

A warning may be expected. The patient looks worried. He may show some pallor about the mouth. There may be slight inco-ordination. The pulse has a peculiar bounding characteristic though it may be fast or slow. Even in mild hypoglycaemia there may be emotional disturbances, laughing, crying or maudlin talk. Not infrequently the condition simulates that of alcoholic intoxication. A less common form is that in which tingling and numbness of the lips and tongue or hands or circumscribed areas of the skin occurs. Typical epileptiform convulsion may occur. This is more common in children. Hypoglycaemia may occur during slumber. Not always is the patient awakened by the symptoms. Unconsciousness does occur as a symptom of hypoglycaemia. It may come on suddenly without warning or during sleep. The effect of insulin may even be carried so far that death will occur.

The treatment is obvious. Orange juice or a small candy is nearly always sufficient. But in more pronounced reactions there may be difficulty in persuading the patient to drink. Moderate force must be used. Glucose or corn syrup can be held in the mouth. Remember that absorption of glucose takes place through the mucous membranes of the mouth. Where consciousness is lost, glucose held in the mouth is still a sensible plan of treatment. Adrenalin chloride 1/2 c.c., 1-1000 should also be given. Adrenalin liberates the stored sugar and will temporarily relieve the upset. But one must not depend on it alone. Always follow adrenalin with glucose. In very severe reactions it may be necessary to administer glucose intravenously. Convenient ampules of 50% glucose are now obtainable.

The penalty for a missed meal may be a severe reaction in an insulin-user. So that when a meal is omitted for any reason, the carbohydrate value should be made up and given in some fashion, such as orange juice or ginger ale.

It would not be fair not to mention broken needles. If care is taken a broken needle can always be caught and withdrawn. Do not bury the needle to the hilt. If 1/3" is left outside it can be caught and retrieved. The break is nearly always at the base of the needle.

I have tried to review briefly the subject in such a way that the problems will be no longer such. There is much more to say but time forbids. I have touched on what I consider essentials in nursing the diabetic. I have till now left out one very important point. Always ask questions when you are not sure. Details of treatment are not constant. You can only do the

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most for your patient by keeping closely informed with every feature of the situation.

Following is a detailed explanation of diet forms prepared by Miss Edith Wark:

QUANTITATIVE DIET FORM

For Date

Prescribed Diet: C. P. F. Cal. Gl.

FOOD	Total Grams	Carb.	Prot.	Fat.	Breakfast	Dinner	Supper
Corn Flakes 30 gms. C. 24.3 P. 1.6 F. .4							
Shredded Wheat 1 C. 23. P. 3. F. 0.							
Rolled Oats, Dry Wt. 30 gms. C. 20. P. 5. F. 2.							
5% Fruit 100 gms. C. 5. P. 0. F. 0.							
10% Fruit 100 gms. C. 10. P. 0. F. 0.							
15% Fruit 100 gms. C. 15 P. 0. F. 0.							
5% Vegetables 100 gms. C. 3. P. 1.5. F. 0.							
10% Vegetables 100 gms. C. 6. P. 1.5. F. 0.							
Fish 30 gms. C. 0. P. 6. F. 0.							
Meat, Lean, Ckd. 30 gms. C. 0. P. 8. F. 3.							
Egg, One C. 0. P. 6. F. 6.							
Cheese 30 gms. C. 0. P. 8. F. 11.							
Bacon, 30 gms. Unckd. C. 0. P. 5. F. 15.							
16% Cream 30 gms. C. 1.3. P-.9. F. 4.7.							
32% Cream 30 gms. C. 1.2. P-.6. F. 9.3.							
Milk 30 gms. C. 1.5. P. 1. F. 1.2.							
Butter 30 gms. C. 0. P. 0. F. 25.							
Total							

Illustrated is the diet form used. The first column, reading from left to right, is the list of foods allowed, with the analysis under each food for the amount given, e.g.: Cornflakes, 30 grams; yields carbohydrate 24.3 grams, protein 1.6 gram, fat .4 gram. The next column gives the total number of grams of each food for the entire day. The analysis of the total grams is in the next three columns. To the right are the total grams divided into breakfast, dinner and supper. So that to find the allowance for each meal read down the column and refer across to the food column.

Reading the breakfast in this diet we have:

30 grams oatmeal;
100 grams 10% fruit;
30 grams bacon;
1 egg;
90 grams 16% cream;
15 grams butter;
1 bran muffin.

Fruit and vegetables, as mentioned previously, are grouped in relation to their carbohydrate content, as 5%, 10%, 15%. At the bottom of the form you will find these classifications. The 10% fruit and vegetables have twice as much carbohydrate as the 5%, the 15% have three times as much as the 5%. So if you wish to have 5% vegetables or fruit instead of 10% vegetables or fruit as allowed in the diet, twice as much could be used, and similarly 2/3 as much of 15%. In the

INSULIN UNITS

Approximate Carbohydrate Content			Non-Nutrients
Vegetables			
Fruit			
5% Asparagus Beet Greens Brussels Sprouts Cabbage Cauliflower Celery Cucumbers Dandelion Greens Egg Plant Lettuce Mushrooms Onions (cooked) Radishes Sauerkraut Spinach String Beans (canned) Tomatoes Vegetable Marrow Watercress 5% Grapefruit Rhubarb	10% Beets Carrots Green Peas (early June canned) Leeks Onions (raw) Oyster Plant Pumpkin Squash String Beans (fresh) Turnips 10% Cranberries Gooseberries Lemons Muskmelons Oranges Pineapple Peaches Strawberries Watermelon	15% Green Peas (fresh) Parsnips 15% Apples Apricots (fresh) Bananas (sun-ripened) Blueberries Cherries Currants (fresh) Pears Raspberries	Agar-Agar Clear Broth Bran Wafers Diabetic Jelly Mineral Oil Clear Tea Clear Coffee Vinegar Salt Pepper Saccharine

Custard C. 4—P. 5.5—F. 5.5

½ egg.
5 tablespoons milk.

Beat egg slightly, add saccharine, vanilla and milk. Bake in a slow oven.

Washed Bran

1 cup of ordinary bran to 3 cups of cold water.

(1) Put on stove and bring to boil.
(2) Drain, add fresh water and repeat above 3 times.
(3) Pour into cheesecloth bag or fine strainer.
(4) Put under running water tap and rinse for 3 or 4 hours.
(5) Place in flat pan and dry thoroughly in warm place.

Brans—No Food Value

3 cups of dry washed bran.
3 tablespoons India gum.
½ tablespoon salt.
1 teaspoon cinnamon.
1 teaspoon nutmeg.
1 grain saccharine.

Mix thoroughly, add warm water to make soft dough. Spread on greased pans. Cut in squares and put in warm place to dry out.

Bran Muffins—12 Muffins

3 eggs.
45 grams butter.
1 cup buttermilk.
½ teaspoon salt.
1 teaspoon baking soda.
2 cups washed bran.

Beat eggs lightly, add melted butter. Add buttermilk mixed with the soda and beat well. Add bran and salt. Bake in a moderate oven for about 30 minutes. Value of 1 muffin: C. 1, P. 2, F. 5.1.

GENERAL INSTRUCTIONS

You are advised to see your physician within one week of discharge from hospital.

About 4 ounces of 24-hour urine should be brought with you on each visit to office.

Colds, any infection, nausea, vomiting, biliousness, should be reported to your physician immediately.

Insulin Patients

You should use 20-unit (Blue Label) insulin, unless otherwise specified.

Urine should be tested for sugar frequently.

If insulin supply should fail, reduce diet by one-third and notify physician.

Should you experience any unusual symptoms, such as weakness, trembling, sudden perspiration, which may be due to an overdose of insulin, take juice of one orange. Repeat orange juice in 10 minutes if no relief. Report to your physician immediately.

Should an unconscious state occur from overdose of insulin, commercial glucose or corn syrup should be forcibly held within the mouth and physician notified immediately.

list for dinner, the allowance of vegetable is 300 grams of 5% vegetable. In place of that, 150 grams 10% vegetable may be used, or 100 grams 15% vegetable, or 100 grams 5% and 100 grams 10% vegetable.

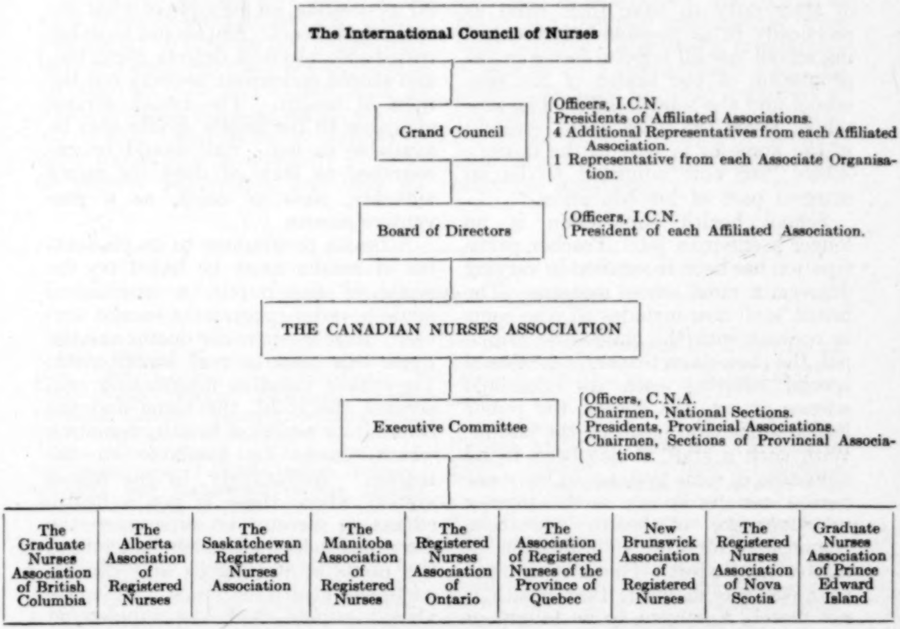
For the allowance of meat, any lean meat may be used: steaks, chops, roasts or stews, in which may be part of the vegetable allowance. If chicken or fish is used, approximately ¼ more should be used with 5 grams extra butter.

A recipe for custard is found on the reverse side of the form illustrated, as is also the recipe for bran muffins and the method of washing bran.

The fruit may be fresh, cooked, or canned without sugar. There are several excellent brands of fruit canned without sugar.

It is quite possible in diabetic diets to give considerable variety and still adhere strictly to the prescribed amounts. As an illustration the supper may be arranged as a salad with cold meat, or a small steak or chop with a scalloped vegetable, using the water in which the vegetable is cooked, a little flour (by leaving out a part of the supper fruit allowance) to thicken it, and washed bran mixed with a small part of the butter allowance to cover; or cheese omelet using in place of the meat allowance an egg with 15 grams cheese. There are endless ways of making the diet enjoyable if one will use a little imagination and patience. Trays and the food on the trays should always be rendered as attractive as possible. Make use of garnishes. A little parsley or mint, etc., will not count in the diet, but will count greatly in the general attractiveness of the meal.

CHART OF ORGANISATION OF THE CANADIAN NURSES ASSOCIATION



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Grand Council
- Officers, I.C.N.
- Presidents of Affiliated Associations.
- 4 Additional Representatives from each Affiliated Association.
- 1 Representative from each Associate Organisation.

Board of Directors
- Officers, I.C.N.
- President of each Affiliated Association.

THE CANADIAN NURSES ASSOCIATION

Executive Committee
- Officers, C.N.A.
- Chairmen, National Sections.
- Presidents, Provincial Associations.
- Chairmen, Sections of Provincial Associations.

The Graduate Nurses Association of British Columbia	The Alberta Association of Registered Nurses	The Saskatchewan Registered Nurses Association	The Manitoba Association of Registered Nurses	The Registered Nurses Association of Ontario	The Association of Registered Nurses of the Province of Quebec	New Brunswick Association of Registered Nurses	The Registered Nurses Association of Nova Scotia	Graduate Nurses Association of Prince Edward Island

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,

Trends in School Health Supervision

By BARBARA A. ROSS, Reg.N., Supervisor of School Nursing, Department of Public Health, Toronto

Some school systems have travelled further along certain lines of health supervision than have others. Accordingly, what may be considered in this article as tendencies are accomplished facts in some health programmes. However, at this stage of school health work, no school has yet realised all its ideals or reached its health goal.

With the recognition that many children enter school with physical and personality handicaps, and that the education of the child begins at or even before birth, there has commenced a strong movement to give the child a square deal by using the opportunities presented in this early period. Medical supervision of the expectant mother, child study and parent education groups, and the recognition by parents of their duty to have their child as physically fit as possible before entering school, are all hopeful forces in the promotion of the health of the preschool and the school child. The preschool years, whether spent entirely in the home or in part in the nursery school, are now admitted to be an integral part of his education.

School health supervision is no longer a one-man job. Teacher participation has been recognised in varying degrees in most school systems. The health staff now includes all who come in contact with the child—the principal, the class-room teacher, teachers of special subjects such as household science or art, the doctor, the public health nurse, and not least the janitor. With such a staff, it has been found advisable in some systems to have one person, usually known as the director or supervisor of health education, responsible for the co-ordination of interest and effort. This arrangement acknowledges in effect that health is not merely a subject to be taught or to be assigned to one corner of the curriculum, but it is a force which should permeate the whole school day.

As it is the classroom teacher who has the greatest contact with the child during school hours, she is the logical person to carry the major responsibility of the daily task of teaching health and of helping to establish health habits and attitudes. The health teacher requires preparation for her work. Post-graduate courses have been available for several years to doctors and nurses. Health teaching and supervision are being included in more normal school programmes and in summer courses for the teacher in service.

It is desirable for effective teaching that the health worker should be, as far as possible, an example of what she is trying to teach. She should have her remediable physical defects corrected, and should endeavour to carry out the rules of health. The health service available to the pupils should also be available to her. She should be encouraged to stay off duty for minor ailments, such as colds, as a preventive measure.

A health programme to be productive of results must be based on the needs of the pupils; a mechanical made-to-order programme cannot succeed. Here is where the doctor and the nurse can make a real contribution. They have valuable information concerning the child, the home and the community aspect of health promotion which should be available to the teacher. Accordingly, in the school system where there is not a health education director or supervisor, the nurse can help the teacher understand the needs of her pupils and can recommend health materials. The nurse always stands ready to supplement the efforts of the teacher in individual and group instruction.

The school physician also lends assistance to other departments directly concerned in the health of the child, such as the physical education department and the special classes. He co-operates with the private physician in order to strengthen the bond between the latter and the family on which basis most of our corrective programme ultimately rests. Notification of the family physician of the results of the school health examination is a step in this direction.

The handicapped child is receiving more attention. Classes for the mentally subnormal and the physically handicapped are increasing in number. Children with less marked defects are looked after in the regular class when the teacher and the nurse are responsible for seeing that each is seated according to his need. In an up-to-date classroom no longer should one see a child hampered with defective vision or hearing sitting in the rear of the room.

With the axiom in mind that all learning is reaching and there is no such thing as passive learning, educationists try to arrange that pupils may have as many opportunities as possible for exercise of health habits, such as washing hands, drinking water, playing out of doors and living in well-ventilated rooms at a temperature of 65 to 68 degrees Fahrenheit, and that instruction may be suitable to the child's intellectual level, may meet his need and appeal to his interest. The laws of learning—mind-set, exercise and satisfaction—are operative in this field of health education as well as in other educational fields.

In the secondary schools, the adolescent needs health supervision and instruction. What has been said regarding healthful environment and a unified programme in the elementary schools also applies to the secondary schools. The health co-ordinator works closely with the heads of those departments which can make the richest contribution to the health education programme. The main approaches are through the student's recently awakened scientific and social interests, and his increased responsibility for personal health habits.

With the recognition of the educability of adults, and also with the desire to leave responsibility where it properly belongs, health educationists are including the parents in their health programme. In many school systems, efforts are made by principal, teachers, school doctor and nurse to reach the parents concurrently with their children. The health programme is undoubtedly strengthened when the parents, because they are cognizant of the health instruction and activities in the school, are in a position to promote, then carry-over into the home and into other life situations.

MISS JOSEPHINE F. KILBURN

Miss Josephine Kilburn, a graduate of the Toronto General Hospital, 1916, on October 15th, 1930, received the appointment of Chief Social Worker, Provincial Mental Hospital, British Columbia, working from the hospital at Essondale.

Miss Kilburn joined the Division of Nursing, Department of Public Health, Toronto, in 1916, and transferred to the Mental Hygiene Division in 1926.

In September of 1926 she was granted a travelling fellowship by the Rockefeller Foundation, and spent six months with the Social Service Department at the Henry Phipps Clinic of Johns Hopkins Hospital, Baltimore. While at Phipps she was under the personal supervision of Dr. Esther Loring Richards, Associate Psychiatrist at the Clinic, and Chief of the Out-Patient Department.

Returning to Toronto in April, 1927, Miss Kilburn continued with the Division of Mental Hygiene as Psychiatric Children's Worker, doing a splendid piece of work with a specially difficult type of child, that is, the child of normal intelligence who manifests behaviour problems of every sort.

Miss Kilburn is being sponsored as Chief Social Worker, Provincial Mental Hospital, British Columbia, by the Canadian National Committee for Mental Hygiene.

The Public Health Nurse's Friend—A Clean Newspaper

By MARGARET E. KERR, Department of Nursing, University of British Columbia.

"May I have a clean newspaper upon which to place my bag?" asks Miss P. H. Nurse as she comes in to a home early in the morning. Then she proceeds to use that piece of newsprint and several others with which we supply her in making pads, bags, rings, etc.

Quite recently the question of the desirability of using newsprint so freely in the care of patients was raised. Was there anything in the composition of the paper or the ink used which was liable to be detrimental to health? Would we be justified in substituting heavy brown wrapping paper instead? How did the manufacture of these two papers differ? These and many other questions came up for discussion, so it was decided to make a brief study of some of the methods used in producing paper.

Newsprint, as made on this continent, commonly consists of from 70 per cent. to 80 per cent. of raw wood, ground into pulp by sandstone wheels, the remaining fibre being sulphite pulp, produced by cooking wood chips in a solution of calcium bi-sulphite. This acid is formed by the reaction between sulphur dioxide and limestone in the presence of water. Both pulps are thoroughly washed and screened in enormous quantities of water, and practically every trace of water soluble material is removed. A very small amount of acid remains and gives the finished product a mild acid reaction. The dark specks commonly found in newsprint consist principally of fragments of bark, with an occasional flake of iron sulphate, produced by reaction of the acid pulp with iron piping, etc.

A small amount of rosin sizing, composed of rosin boiled with a solution of sodium carbonate, is generally added, and is firmly affixed to the fibre by the addition of sulphate of alumina, a substance very similar to common alum. The resulting coating of resinate of alumina is quite inert and insoluble, but it is usual to employ an excess of papermaker's alum, which further increases the acidity of the product.

During the various processes, and particularly in warm weather, a bacterial growth occurs in the pulp, converting a small part of it into a slimy matter, which may sometimes be seen in the paper in the form of translucent spots, or holes ringed with brown or grey. This is sometimes combatted by the addition of small quantities of liquid chlorine to the stock, but the bacterial matter is quite harmless.

From one to four ounces of blue dyestuff per ton of paper is used to improve the colour, but the usual dye is non-irritating and non-poisonous to the skin or to open wounds.

The better grades of heavy kraft paper (brown wrapping paper) consist almost entirely of a chemical pulp produced by cooking the wood in a caustic alkali solution; sodium hydrate (caustic soda), and sodium sulphide. The washing process is exceedingly thorough and a slightly greater quantity of rosin sizing is added, with a corresponding amount of alumina sulphate, which may make the paper mildly acid. Kraft paper is much more inert and less subject to deterioration and chemical alteration than newsprint, but none of the chemicals employed appear to be harmful in any way in the concentration in which they are found in either variety of paper.

In both kinds, after the sheet is formed, it is dried by being firmly pressed against the surfaces of from thirty to fifty steam heated steel cylinders, at a temperature of from 220° to 300° Fahrenheit for a period of from three-quarters to two and a half minutes, the heavier kraft paper requiring the longer time. This kills the slime bacteria and is probably equally efficacious in the sterilisation of the paper against other chance organisms.

After drying, the paper is wound into reels, and rewound into smaller rolls. Any part of the surface may be touched by the hands of the workmen, who locate defects by the sense of touch. In printing, newspapers are rarely handled, and the ink, a combination of finely divided carbon in linseed oil, is quite harmless. In the paper mill, new newsprint is used daily in lieu of towels and apparently causes no harm.

Public health organisations in Canada and United States have looked upon the newspaper as indispensable equipment in the care of the patient in the district home. In Europe the general practice has been to use the kraft paper. It is purchased in large rolls by some of the organisations, and is carried into the home by the nurse as required. Visitors from Europe exclaim at the frequency and imperturbability with which the nurse on this side of the Atlantic uses newspapers.

There appears to be no inherent danger in the use of either kind of paper, from any of the materials or chemicals employed in their manufacture. The kraft paper is much stronger and more waterproof. The real problem lies in the possibility of bacterial contamination of either or both forms of paper, more particularly after it enters the home. The danger from the bacteria on the paper depends, of course, on the form present and on the recency of contamination. Apart entirely from the bacteria present, there is the ever-present possibility of a dirty paper: from the grubby hands of the newsboy—from the verandah or walk where he has thrown the paper—from all the members of the household who have pored over the last crossword puzzle—from their shoes as they trampled on the paper that had been carelessly dropped on the floor. Similarly, brown paper that comes into the home wrapped around parcels may be soiled or crumpled.

If it is agreed that the use of paper is a convenience in home care, it should be possible for any nursing organisation to purchase rolls of either kraft paper or new newsprint with which to supply the patients, particularly when the paper is to be used directly in the care of the patient.

News Notes

INFORMATION WANTED

"The Canadian Nurse" has received a request through The Canadian Red Cross Society from Mr. Francis McGinn, a war veteran who wishes to locate his two sisters, Misses Mary and Jean McGinn, graduates of The Belfast Hospital. The Misses McGinn served in England and France during the War. Their brother has not heard from them since his demobilisation, but understands they came to Canada in 1921.

Anyone able to assist Mr. McGinn is asked to write to him care of the General Post Office, Adelaide St. East, Toronto, Ont.

ALBERTA

Calgary: Miss H. Rach has accepted a position on the staff of the Coleman Miners' Hospital, Coleman, and Miss H. Terry on the staff of the Mental Hospital, Ponoka. The annual bridge of the Calgary Association of Graduate Nurses was held in the Col. Belcher Hospital Recreation Rooms on November 27th. A most enjoyable time was had by a large number of nurses and their friends. The luncheon given by the Alberta Hospitals Association and Alberta Association of Registered Nurses in the Alhambra, The T. Eaton Company, on November 13th, was largely attended by representatives from both associations—out-of-town and local. The annual meeting was very well attended and enjoyed.

BRITISH COLUMBIA

General Hospital, Vancouver: At the last regular meeting of the Alumnae, the very serious problem of unemployment among nurses was again discussed and ways of improving conditions considered. It was finally decided to send notices to all nurses on the registry, that if necessary they may borrow money for three or four months at three per cent interest. The sick benefit fund money on hand is to be used for this purpose, as it is quite clear there will soon be more sick nurses if help of some kind is not available. During the evening Miss Isobel MacVicar was presented with a little finger ring, as a small token of appreciation of her efforts in connection with the making of money for the Sick Benefit Fund. The Christmas gifts purchased for members of the alumnae who are ill at present, were on display and approved by all present. After several years in Boston, and a trip to the continent this spring, Miss Cora Tretheway has returned to her home in Vancouver. Miss Lillian Weir is another recent visitor in the city. She is on her way back to San Francisco after several months in New York. Miss Mary McPhee has recently taken a position with the Child Hygiene Department of the Vancouver City Health Department. Mrs. Briggs (Miss Bunbury, V.G.H.), has accepted a position on the staff of the Vancouver General Hospital.

St. Joseph's Hospital, Victoria: At the annual meeting of the Alumnae Association officers for 1931 were elected. The Honorary President is S. M. Mildred, Superior; Honorary Vice-President, S. M. Gregory; President, Miss E. Lewis; First Vice-President, Mrs. E. Stibbard; Second Vice-President, Mrs. A. Welch; Treasurer, Miss E. Bird; Recording Secretary, Miss Doris Grubb; Corresponding Secretary, Miss H. Cruickshank; Councillors, Mrs. S. Kenning, Misses M. Patterson, J. Down, and H. Maegher. Visiting Sick Committee, Mrs. J. M. Fowler, Mrs. J. N. Moore, Mrs. B. Ford, Mrs. K. Fraser; Reporter to "The Canadian Nurse," Miss N. Martin. A bursary of one hundred dollars was presented to Miss E. Bird, who obtained second highest standing in the Province in the recent examinations for registration of nurses. Plans formulated for the year's work were discussed, i.e., to assist the Hospital in its activities; to assist the training school; that an increase be made in the Scholarship Fund by the establishment of a Loan Fund. (Later it was decided that funds be raised to establish the Loan Fund.)

A bridge party was held in the Nurses Home on October 15th, when an enjoyable evening was spent by all. Following the business meeting, Miss Thornley, supervisor of the V.O.N. in Victoria gave a very instructive talk on the history and administration of the Order, especially that of the local Order. The senior nurses were the guests of the Alumnae at this meeting.

Miss Ursula Whitehead, formerly instructor of nurses of the Royal Jubilee Hospital, has accepted a position as matron of the Duncan Hospital. Graduates on staff duty at various hospitals are: Gwendolin Carey (1928), who has just completed a post graduate course at the Mayo Clinic, Rochester, Minn., has accepted a position on the staff. Alice Cumberland (1928), North Vancouver Hospital; Eleanor Whitehead (1926), General Hospital, Trail; Dora Pearson (1925), Vernon Hospital, Vernon; Kathleen Townsend (1927), Tranquille Sanatorium, Kamloops; Edith Olsen (1926), Victorian Order of Nurses, Victoria; Clare Rose (1925), Public Health, Saanich Health Centre; Irene Wheldon (1927), Campbell River Hospital; Phyllis Dalziel, Mary Dell, and Bernice Bittancourt, Cedar of Lebanon Hospital, Los Angeles, California, Elsie Fairhurst (1928), General Hospital, Mabel Anderson (1928), and Ida Ruce (1928), General Hospital, Chemainus; Florence Sehl (1918), Matron, General Hospital, Cumberland; Jean McEwan (1920), and Bessie M. Reid (1918), Stanford University Hospital, San Francisco; Marion Bellis (1928), St. Joseph's Hospital, Comox; Irene Dynis (1928), Emmanuel Hospital, Portland, Oregon; Bessie Bell (1929), St. Mary's Hospital, New Westminster; Doris Humphries (1929), Edith O'Brien (1929), and Violet Hemer (1930), General Hospital, Nanaimo; Dorothy Giles (1930), Queen Alexandra Solarium, Cobble Hill; Rose Moran (1930), and Dorothy Clayton (1930), St. Mary's Hospital, Dawson; Margaret Service (1927), and Mollie Hardy (1927), Providence Hospital, Seattle, Wash.; Nan Smith (1930), General Hospital, Ocean Falls; Mary O'Hagan (1930), General Hospital, Powell River; Esther Bird (1930), St. Joseph's Hospital, Victoria; Edith Bryce (1929), Fort Sanitorium, B.C.

Post Graduate Courses are being taken by Eunice McDonald and Norah Knox at The Montreal General Hospital; Kathleen Townsend, Margaret Stow, Margaret Armstrong, and Kathleen Gunn, Hospital for Sick Children, Toronto; and Gwendolin Pontifix, University of British Columbia.

MANITOBA

Brandon: At a meeting of the Brandon Graduate Nurses Association held recently at the nurses residence of the Mental Hospital, Dr. T. A. Pincock, Superintendent of the Hospital, was the speaker of the evening. Miss C. Lynch, representative president for the Mental Hospital nurses, introduced Dr. Pincock, who spoke in a most interesting manner on medicine in ancient China. Dr. C. A. Barager, of Edmonton, and Dr. S. J. S. Peirce, were very welcome guests during the latter part of the meeting. The business session of the meeting was presided over by Miss M. Finlayson, President of the Association, when the members decided to donate $25.00 for Christmas cheer in Brandon. A social half hour was enjoyed at the conclusion of the meeting.

Misericordia Hospital, Winnipeg: A meeting of the Alumnae Association was held at the Hospital on December 1st, 1930, when Miss Carruthers, speaker of the evening, gave an interesting outline of the organisation of the Manitoba Association of Registered Nurses. At the conclusion of the meeting, refreshments were served.

On December 3rd, a dance was held in the Picardy Salon, when, amidst streamers and balloons, a large number of nurses and their friends enjoyed an evening of dancing and social intercourse.

The Alumnae extends to Miss C. J. Bodin sincerest sympathy in the death of her father, which occurred on December 5th.

NEW BRUNSWICK

Fisher Memorial Hospital, Woodstock: Diplomas were presented to five nurses at the graduation exercises of the Fisher Memorial Hospital on Friday evening, November 28th, 1930, in the assembly hall of the Fisher Memorial School. The graduates were: Catherine Elizabeth Crabb, Jane Frances Williams, Eva Mae McGrath, Winnifred Margaret Davies, and Faye Elizabeth Mersereau. The diplomas were presented by Mayor G. C. Campbell; Mr. C. W. Clarke presided. The address to the Graduating Class was given by Dr. Belyea, and the Class Prophecy, by Miss J. F. Williams.

Miss Elsie Tulloch, Matron of the Fisher Memorial Hospital, attended the November meeting of the Board of Examiners in Saint John. Miss Helen Melville has resigned from the staff of the Presque Isle Sanitarium owing to ill health. Miss Mary Wetmore, who for the past four weeks has been visiting in Boston, has returned to her home in Woodstock. Miss Grayce Tomms has accepted a position on the staff of the Edmundston Private Hospital.

General Public Hospital, Saint John: Mrs. E. Bassett, of Fairmont, Minn., first matron of the General Public Hospital, who helped establish the first training school for nurses at the hospital in 1888, gave a very interesting talk on her early experiences in nursing when she addressed the members of the Alumnae on October 8th. Mrs. Bassett and Miss Gertrude Mitchell were special guests. Mrs. John H. Vaughan, the President, was in the chair and there were thirty nurses present. Mrs. Bassett was a graduate of the Boston City Hospital Training School, and among other interesting experiences she told of having at one time nursed a man who had been a patient of Florence Nightingale. Miss Sarah Brophy was the Alumnae's delegate at the annual meeting of the provincial association of registered nurses, and she brought back a very interesting report of that convention. Following routine business a social hour was enjoyed.

Saint John Infirmary: The annual meeting of the Alumnae was held on October 6th with Miss M. Downing in the chair. Miss Vesta Farren gave a report of the activities of the past year, and the treasurer, Miss M. Carey, in her financial statement, showed the Alumnae had a good balance on hand. Officers for the ensuing year were elected as follows: President, Miss M. Downing; Vice-President, Miss N. Jennings; Secretary, Miss N. Callaghan; Treasurer, Miss M. Nagle; additional members of the Executive, Miss Mary Baxter, Miss Mary Milan and Miss Josephine Kaine.

At the annual graduation of nurses held on October 8th, in the Y.M.C.A., eight young women received their diplomas which were presented by Bishop LeBlanc. The class was addressed by Rev. Dr. Charles Boyd, and the class prophecy was given by Miss Cyrella O'Reilly. The Infirmary Alumnae prize of $10.00 in gold, awarded for efficiency was won by Miss Kathleen Allison; the prize given by the medical staff for highest marks in theory was awarded to Miss M. A. Keezer.

Saint John: Miss Gladys Crowley (General Public Hospital), who has been for some time engaged in private duty nursing,

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has recently joined the staff of the East Saint John Tuberculosis Hospital.

Miss Bessie Folster (Chipman Memorial Hospital, 1930) recently joined the night staff at the East Saint John Tuberculosis Hospital.

Miss Vera Marr (Victoria Public Hospital, 1927) has resigned her position on the night staff of the East Saint John Tuberculosis Hospital. The vacancy has been filled by Miss Marie Desjardins (Victoria Public Hospital).

NOVA SCOTIA

Nova Scotia Hospital, Halifax: Eight nurses graduated from the Nova Scotia Hospital on the evening of October 30th, 1930. Hon. John Doull presented the diplomas and prizes to the graduating class. The Florence Nightingale Pledge was administered by Dr. F. E. Lawlor and Dr. A. McD. Morton gave an inspiring address to the graduates. After the exercises a dance was held in the recreation hall.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in December, 1930, were 1,188, five more than in November, 1930.

Appointments

General Hospital, Toronto: Miss Florence Kelsey (1923), has returned to the staff of the Hospital, in charge of the Metabolic Research Department of the University at the Burnside Hospital.

Western Hospital, Toronto: Miss Mary Bird (1927), Supervisor, Probationer's Ward Work.

District 1

Victoria Hospital, London: Under the auspices of the Alumnae, the student nurses and the Isobel Hampton Chapter of the I.O.D.E., on the afternoon and evening of November 19th, 1930, a very successful bazaar was held in the Gartshore Memorial Residence. In the evening, George Ollman's Orchestra was in attendance, and dancing was the special feature of the programme.

The Sarnia General Hospital: The following officers were elected for 1931. Honorary President, Miss M. Lee; President, Miss L. Siegrist; Vice-President, Miss J. Hodgins; Treasurer, Miss M. Wood; Secretary, Miss S. Trea; Correspondent to "The Canadian Nurse", Miss D. Shaw; Flower Committee, Miss H. Abra, Programme Committee, Miss A. Silverthorne, Miss C. Medcraft, and Mrs. S. Elrick; Social Committee, Miss B. MacFarlane and Mrs. Kennedy. The Alumnae held a tea on November 12th at the Nurses Residence in honour of Miss Scott, Superintendent, who has accepted the position as Superintendent at Kitchener-Waterloo Hospital. Miss Scott was presented with a travelling clock. A tea and handkerchief shower was given for Miss Lumby, Assistant Superintendent, by the Alumnae and a number of outside graduates before leaving for London where she is taking a Certified Instructor's Course.

District 4

General Hospital, Hamilton: The sympathy of the Alumnae is extended to Mrs. P. E. Forrester (Elsie Yetman, 1922), on the death of her husband, Peter Earl, which occurred in Detroit, Mich., on October 26th, 1930; and on the death of her brother Richard G. Yetman, recently of Harbour Grace, Newfoundland.

Mack Training School, St. Catharines: The regular monthly meeting of the Mack Training School Alumnae was held at the Leonard Nurses Home on November 12th. After routine business, members of the Graduate Nurses Association, Alumnae and pupil nurses enjoyed a most interesting and instructive address given by Dr. Finlayson, of the Mental Health Clinic in Hamilton; Miss Oliver, social worker of the Clinic, clearly defined that phase of the work being done by the clinic; Miss Davis, psychologist, told of the value of this branch in later adjustments in children. Although the Clinic was recently started in Hamilton, it is now extending to Brantford, St. Catharines and other centres. A vote of thanks was extended to the speakers by Miss Johnston and Miss Ridge.

The regular monthly meeting of the Mack Training School Alumnae was held at the Leonard Nurses Home, on December 3rd, Miss Helen Brown presiding. During the business session, one hundred dollars was voted to be used for Christmas Cheer, part of the money being given to the Local Council of Women and to Miss Read and Miss Leofler, public health nurses, to be distributed where most needed. Following this session, Rev. M. C. McLean gave a very interesting and instructive talk on "Present Social Conditions and probable future problems resulting from the unemployment situatoin." A vote of thanks to Mr. McLean for his enlightening talk was moved by Miss Moyer, seconded by Mrs. Ockenden, and carried unanimously.

District 5

The regular meeting of District No. 5, Registered Nurses Association of Ontario, was held November 19th, 1930, in the Physics Building, Toronto, with Miss Ethel Greenwood in the chair. The advisability of organising within the district the three sections, Private Duty, Nursing Education, and Public Health, was the subject of an interesting discussion. The need for such organisation has been felt particularly by the nurses engaged in private duty work. It was finally decided to form the Section, but the details of organisation are to be left to the Executive Committee. Miss Ethel Johns was the speaker of the evening. Her inspiring address will be published in an early number of "The Canadian Nurse," and will give the readers an opportunity of sharing the enjoyment experienced by the fortunate nurses of District No. 5.

Western Hospital, Toronto: A regular meeting of the Alumnae was held November 11th, 1930, in the Edith Cavell Residence. Dr. C. Stewart Wright addressed the members

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on the subject of treatment and nursing care of arthritis. Another life membership was added to the already fairly large list, Miss Laura Turton (1910), being the honoured member. Miss Isabel J. Dalzell (1923), has been appointed Psychiatric Children's Worker with the Division of Mental Hygiene of Toronto, Public Health Department. Miss Elizabeth Kneeshaw (1910), and Miss Laura Turton (1910), are both recovering favourably following operations in Toronto Western Hospital. Miss Kathleen Carmichael (1924), who has been critically ill in Smith Falls General Hospital is reported slightly improved.

St. John's Hospital, Toronto: The members of the Alumnae held their annual meeting, November 19th. Previous to the meeting the Sisters of St. John the Divine entertained Miss Mitchell, of North China, and the Alumnae at a delightful turkey dinner, after which Miss Mitchell spoke in an interesting manner about her experiences in China, and the conditions encountered when nursing there.

General Hospital, Toronto: Miss Lorena M. Chute (1921), a member of last year's class in Hospital Administration and Teaching, University of Toronto, sailed on October 3rd for Vellore, India, where she will have charge of The Vellore Medical College Hospital. Miss Chute has been a very sincere worker on the staff of the Toronto General Hospital since her graduation and her departure is regretted by all. She carries with her the best of good wishes for continued success and happiness in her work.

QUEBEC

Jeffery Hale's Hospital, Quebec City: Changes on the staff are as follows: Miss E. McHarg has replaced Miss A. Ascah as operating room supervisor. Miss Anderson (Riverdale Hospital, Toronto) has accepted the position as instructor, succeeding Mrs. G. Elliott, who has joined the staff of the Shawinigan Falls General Hospital. Miss R. Biden, Dietitian, resigned recently to accept a position in Western Canada. She has been replaced by Miss Macdiarmid. Miss Lyla Moore (1927) has succeeded Miss E. McHarg as night supervisor. Miss Gladys Campbell (1926) has returned to Quebec after spending a month in Arvida, Que. The Misses Lunam and McHarg entertained recently at an enjoyable shower in honour of Miss Ada Ascah prior to her marriage.

The Montreal General Hospital: Miss Strumm has returned from Nova Scotia and has resumed her duties as first assistant Montreal General Hospital. Miss H. Dunlop has taken the position of school nurse at Elmwood Girls School, Rockcliffe Park, Ottawa, Ontario. Miss D. MacDermott (1921), is doing school nursing in Vancouver, B.C. Miss Edythe Ward (1924), has been appointed Assistant Superintendent at Brightlook Hospital, St. Johnsbury, Vermont. Miss I. L. Parker (1930), is taking a post graduate course in operating room work Montreal General Hospital. Miss O'Hara (1926), has returned from New York where she has been taking a Post Graduate course at the Rockefeller Institute, and is now doing private nursing. The sympathy of the association is extended to Miss K. Porteous (1929), on the death of her brother.

The Western Hosptial, Montreal: The Alumnae gave a dinner on November 18th, 1930, in the Lounge Room of the Nurses' Home. Dr. Grace Ritchie, of England, gave a very interesting talk on Citizenship.

Miss Grace Munro was operated on recently for tonsillectomy at the Montreal General Hospital, Western Division. Miss H. Chisholm left recently for Bermuda, where she will engage in nursing. Miss Hazel Kerr is doing private duty nursing in France during the winter months. Miss Beatrice Jacques is at present nursing in Quebec City. Miss Tyrrell has returned from her trip to the Coast. Miss Birch visited the hospitals of Philadelphia and New York recently.

SASKATCHEWAN

City Hospital, Saskatoon: Miss E. Ratcliffe is in charge of the pediatrics department. Miss Margaret Robb, who has been on the special nurses staff at St. Mary's Hospital, Rochester, Minn., for the past year, is now doing staff duty at San Diego, California. The November meeting of the Alumnae took the form of a bridge, when a very enjoyable evening was spent. Misses Ruth Taylor and A. Silverthorn were in charge of the arrangements. The senior class (1931) were the guests of the Alumnae.

C.A.M.N.S.

Windsor, Ont.: The annual dinner of the Overseas Nurses Club was held in the Prince Edward Hotel on November 18th. A representative number of nurses was present. The table was beautifully decorated with scarlet and white carnations interspersed with which was the Union Jack. A few candles in saucers reminded the diners of the "good old times" when meals were served more simply. The following officers were elected: President, Miss Nellie Gerard; Vice-President, Mrs. Gilbert Storey (Marion Starr); Secretary-Treasurer, Mrs. M. R. Graham.

Montreal: The Montreal Unit of the Overseas Nursing Sisters Association of Canada held its second Armistice Dinner on Armistice Night, November 11th, 1930, at the Queen's Hotel. For various reasons several of the members were unable to attend, which is to be regretted, for the party was a very jolly one, and long to be remembered by all who had the good fortune to be present. The toast to "Absent Friends" was proposed in a charming manner by Mrs. Stuart Ramsey, President of the Overseas Nursing Sisters Association of Canada. The guest of honour, Miss E. L. Smellie, Chief Superintendent of the Victorian Order of Nurses, gave a most interesting address, the audience entering into repeated peals of laughter at the stories she told. All who know Miss Smellie will realise what a very jolly time she gave the Montreal group.

The silent toast to our "Glorious Dead" was proposed by Mrs. MacDermot.

"They shall not grow old as we who are left grow old,
Age shall not weary them, nor the years condemn,
At the going down of the sun and in the morning
We will remember them."

WINNIPEG: An Armistice Tea was held on November 11th at the Marlborough Hotel, Miss McGillivray, President, and Miss K. McLearn, Social Convener, receiving the guests. The tea table was presided over by Mrs. C. W. Davidson, Miss Jean Wilson, Miss A. Starr, and Miss Polexfen. Those helping to serve were: Mrs. T. Cavanagh, Miss J. Barton, Miss E. Parker, and Miss J. MacDonald.

An Armistice and Memorial Service for the late Major The Rev. Wm. Robertson was held in St. Saviour's Church on the evening of November 16th, conducted by Capt. Talbot. The lesson was read by officers from the barracks. Officers and men representing the garrison of Military District No. 10 were present, and four nursing sisters in uniform attended. Capt. Talbot, who had been very closely associated with Major Robertson overseas, spoke very feelingly of the great loss sustained by the community in the passing of Major Robertson. Before the close of the service a beautiful baptismal font was dedicated to the memory of the late beloved padre.

AN OMISSION

Owing to an oversight when publishing A Digest of Laws and Regulations Governing the Registration of Nurses in Canada, in the December number of the Journal, the name of the nurse who had prepared the Digest was omitted. The material was prepared by Miss E. Francis Upton, Executive Secretary and Registrar, Association of Registered Nurses for the Province of Quebec, as part of a course in Nursing Legislation given by Miss Upton at the School for Graduate Nurses, McGill University, Montreal.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

BARNBY—On November 1st, 1930, at London, Ont., to Dr. and Mrs. T. I. Barnby (Effie Wilson, Victoria Hospital, London, Ont.), a daughter.

BRECKENRIDGE—On November 18th, 1930, to Mr. and Mrs. Charles Breckenridge (Eva Archer, Nicholls Hospital, Peterboro, Ont., 1918), a son.

BULL—On June 24th, 1930, to Mr. and Mrs. Allan Bull (Belle Cummings, Fisher Memorial Hospital, 1924), a daughter, Cora Eileen.

CALVIN—On November 24th, 1930, to Mr. and Mrs. Calvin (F. Mooers, Toronto General Hospital, 1924), a son.

CARTWRIGHT—On November 22nd, 1930, to Mr. and Mrs. R. A. Cartwright (Bertha Knox, Toronto General Hospital, 1919), a son.

CRICKARD—On November 28th, 1930, at Vancouver, to Mr. and Mrs. Frederick Crickard (Carrie Robson, Vancouver General Hospital), a son.

DIEDRICH—On November 18th, 1930, to Mr. and Mrs. Diedrich (Winnifred Kent, Toronto General Hospital, 1919), a son.

FERGUSON—On October 19th, 1930, at Detroit, Michigan, to Mr. and Mrs. A. Dale Ferguson (Rosabelle Brooks, Nicholls Hospital, Peterboro, Ont., 1922), a daughter.

FRAYNE—Recently, at Cornwall, Ont., to Mr. and Mrs. Maurice Frayne (Doris Rand, Cornwall General Hospital, 1929), a daughter.

GRAY—On October 17th, 1930, at Victoria, B.C., to Mr. and Mrs. Herbert Gray (Winnifred Calvert, St. Joseph's Hospital, Victoria, 1927), a son.

HAWKLEY—On November 17th, 1930, at Montreal, to Mr. and Mrs. Frank Hawkley (Edith Black, Montreal Western Hospital), a son.

MARSHALL—On August 1st, 1930, to Mr. and Mrs. Fleetwood Marshall (Nellie Anderson, Fisher Memorial Hospital, 1924), a son, Charles Lister.

MENEILLEY—On July 14th, 1930, at Peterboro, Ont., to Mr. and Mrs. Charles Meneilley (Winnifred Raby, Nicholls Hospital, Peterboro, Ont., 1925), a son.

MORRISON—On November 1st, 1930, at Peterboro, Ont., to Mr. and Mrs. Geo. Morrison (Hazel Whitfield, Nicholls Hospital, Peterboro, Ont.), a daughter.

McFALLS—On November 11th, 1930, at London, Ont., to Mr. and Mrs. Grant McFalls (Vilma Bilzen, Victoria Hospital, London, Ont., 1925), of Exeter, a daughter.

McLEOD—On October 20th, 1930, to Mr. and Mrs. M. McLeod (Jane Burrows, Regina General Hospital, 1926), a son.

READ—On November 30th, 1930, at London, Ont., to Dr. and Mrs. Arthur Read (Kay Read, Victoria Hospital, London, Ont., 1924), a son.

ROWE—In October, 1930, at Cornwall, Ont., to Mr. and Mrs. Carman Rowe (Freda Shouldice, Cornwall General Hospital, 1926), a son.

TAYLOR—On August 3rd, 1930, at Saskatoon, to Mr. and Mrs. J. B. Taylor (Bessie Johnson, City Hospital, Saskatoon, 1929), a son, Gerald Hugh.

THOMPSON—Recently, to Mr. and Mrs. W. J. Thompson (Elvira Handley, St. Catharines General Hospital, 1928), a daughter.

WELLS — In August, 1930, at Quebec, to Dr. and Mrs. T. J. Wells (Florence Hillier, Jeffery Hale's Hospital, Quebec), a daughter.

MARRIAGES

ANDERSON—WHINBEY — Recently, at Montreal, Florence Whinbey (Western Hospital, Montreal) to Roland Anderson.

AYRE—FOLLETT—In June, 1930, at New York, Eva Follett (Fisher Memorial Hospital, 1929), to Gordon Ayre.

BARKLEY—MELDRUM — In October, 1930, at Ottawa, Ont., Olive Meldrum (Cornwall General Hospital, 1925), to Dr. A. Barkley.

BARTLETT—LUMSDEN—On December 2nd, 1930, at Kamloops, B.C., Helen Marjorie Lumsden (Vancouver General Hospital, 1919), to Rev. Ernest R. Bartlett, of Ashcroft, B.C.

BENNETT—DETHRIDGE — On October 24th, 1930, at Regina, Sask., Constance Dethridge (Regina General Hospital, 1930), to James Earl Bennett, of Wolseley, Sask.

BINET—SILAS—On October 15th, 1930, at Quebec, May Silas (Jeffery Hale's Hospital, Quebec, 1930), to Edwin T. Binet. M.D. of the Magdalen Islands.

BROWNRIGG—WINSOR — On October 26th, 1930, at Montreal, P.Q., Miss E. M. Winsor (The Montreal General Hospital, 1930), to G. M. Brownrigg.

CARR—McRAE—On November 1st, 1930, at Barre, Vermont, Mrs. Mabel McRae (The Montreal General Hospital, 1924), to Perley M. Carr.

COLLINS—DUNCAN—On June 21st, 1930 at Sarnia, Ont., Aileen Duncan (Sarnia General Hospital, 1929), to Earl Collins, of Sarnia, Ont.

COLLINS—SCOTT—On August 8th, 1930, at Wingham, Ont., Anne Scott (Sarnia General Hospital, 1928), to Robert Collins, of Sarnia, Ont.

CUMING—MacLEOD—On October 6th, 1930, at Bury, Quebec, Mildred C. R. MacLeod (Jeffery Hale's Hospital, Quebec, 1927), to Percy Cuming, of Sherbrooke.

DITCHBURN—MACAULEY—On September 2nd, 1930, at Seattle, Wash., Claire Macauley (St. Joseph's Hospital, Victoria, 1929), to Raymond Ditchburn, Victoria, B.C.

DOHERTY—KENNEDY—In June, 1930, at Quebec, Jennie Kennedy (Jeffery Hale's Hospital, Quebec, 1921), to Charles Doherty.

HARRISON—BANKS—On December 2nd, 1930, at Vancouver, Dorothy Banks (Vancouver General Hospital), to Dr. W. Elliott Harrison.

HENDRIX—MAYNARD — On October 18th, 1930, at Seattle, Washington, Margaret Catherine (Peggy) Maynard (Vancouver General Hospital), to James Myron Hendrix.

HOPTON—DEACON—On November 10th, 1930, at Victoria, B.C., Caroline (Peggy) Deacon (St. Joseph's Hospital, Victoria, 1928), to Frederick H. Hopton.

JOHNSTON—McMASTER—On September 1st, 1930, at Covina, Cal., Gladys McMaster (Cornwall General Hospital, 1925) to Robert Burney Johnston.

KENNEDY—WATSON—On July 5th, 1930, at Sarnia, Ont., Jeanette Watson (Sarnia General Hospital, 1924), to Dr. E. L. Kennedy, of Sarnia, Ont.

LOYD—RAYNER — On November 5th, 1930, at Unity, Sask., Josephine Rayner (The City Hospital, Saskatoon, 1929), to B. Loyd.

McGINIS—GIBBS—In July, 1930, at Victoria, B.C., Helen R. Gibbs (St. Joseph's Hospital, Victoria, 1929), to Lamont E. McGinis.

NEWTON—JACKSON — Recently, at Navan, Ont., Maude Jackson (Cornwall General Hospital, 1928), to William Newton.

NORTHRUP—ATKINS—In October, 1930, Anne Atkins (Vancouver General Hospital, 1924), to Kenneth Le Roi Northrup.

PAGE—ARGUE—On November 12th, 1930, Kathleen Argue (Winnipeg General Hospital, recently of the staff of Vancouver General Hospital), to Ralph Page, of Fresno, California.

PLUMMER—LAUGHER—On August 25th, at Pembroke, Ont., Sicily Laugher (Sarnia General Hospital, 1924), to Lorne Plummer, of Port Hope, Ont.

SEALE—ASCAH—On September 6th, 1930, at Quebec, Ada M. Ascah (Jeffery Hale's Hospital, Quebec, 1926), to Earl Seale, of Quebec.

THOMPSON—BIGNELL—On October 4th, 1930, at Quebec, Gwendolyn Constance Bignell (Jeffery Hale's Hospital, Quebec, 1926), to Fred Thompson, of Montreal.

WILSON—LADELL—On November 1st, 1930, at Kamloops, B.C., Margaret Ladell (St. Joseph's Hospital, Victoria, 1927), to Earl B. Wilson, of Summerland, B.C.

WILSON—WEBB—On September 3rd, 1930, Maud Rogers Webb (Toronto General Hospital, 1914), to Dr. Cleveland Roy Wilson.

DEATHS

MacKEDDIE—On October 15th, at Quebec, Margaret MacKeddie (Jeffery Hale's Hospital, Quebec, 1904).

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Regular Meeting—First Tuesday in month.

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Meetings—Second Wednesday each month, 8 p.m., St. Boniface Nurses Residence.

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Meetings held first Thursday every month.

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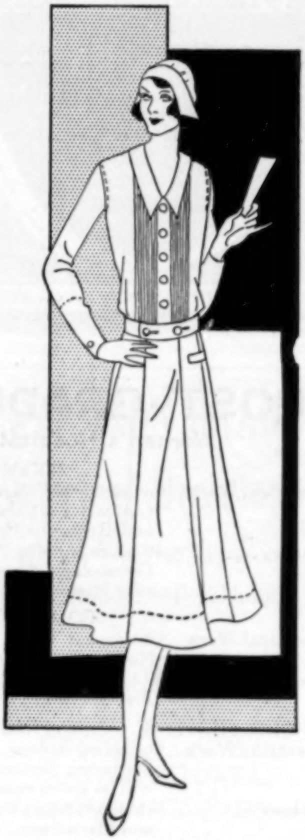

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412 St. Sulpice Street, MONTREAL, P.Q.

Why liquid magnesia is best

A LIQUID diet is kind to an upset stomach. Solids often irritate its over-sensitive condition.

Dry magnesia will not dissolve in water. When compressed into tablets or wafers, magnesia becomes still more insoluble, with danger of passing through the stomach and intestines as irritating grit.

Phillips Milk of Magnesia is a liquid—the only form in which true Milk of Magnesia can be made. This fluid magnesia is immediately active. It has the strong affinity for acids common to hydrates. It will not form concretions or accumulate in the bowels.

No irritation or other harmful effects can follow its administration even under prolonged use. It is the safest and most dependable form of magnesia for infants and children. It is the appropriate laxative anti-acid for adding to milk mixtures intended for bottle fed babies.

The bland aperient action of Phillips Milk of Magnesia is due in large part to its liquid colloidal state, which causes softer evacuations than would otherwise occur.

GENUINE PHILLIPS MILK OF MAGNESIA